STUDY OF THE IMPLEMENTATION OF OMH'S BILINGUAL/BICULTURAL SERVICE DEMONSTRATION PROGRAM

FINAL REPORT

Contract #282-96-0019

August 17, 1998

Submitted to:
Division of Policy and Data
Office of Minority Health
U.S. Department of Health and Human Services
Rockville, MD 20852

Submitted by:
Development Services Group, Inc.
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Table of Contents

CHAPTER I

Introduction

BACKGROUND AND MANDATE

The Final Report that follows represents the results of data collected for the Office of Minority Health (OMH) under the ***Study of the Implementation of the Bilingual/Bicultural Service Demonstration Grant Program***, conducted by Development Services Group, Inc., under Contract #282-96-0019. Contract activities began on October 1, 1996 and ends with delivery of this Final Report on August 15, 1998.

The **Bilingual/Bicultural Service Demonstration Grant Program** (hereafter called the OMH Grant Program) grew out of several Congressional mandates to OMH. Since its inception in 1985, OMH has been the unit of the U.S. Department of Health and Human Services (DHHS) that coordinates Federal efforts to improve the health status of racial and ethnic minority populations. The agency was established legislatively with the passage of the *Disadvantaged Minority Health Improvement Act* (Pub. L. 101-527) and given a broad mandate to advance efforts to improve minority health. To achieve this broad goal, the agency has supported research, demonstration programs, and evaluations of new and innovative programs that:

- Increase understanding of disease risk factors and
- Support improvement of information dissemination, education, prevention and service delivery to minority communities.

Moreover, a Congressional committee charged OMH to "develop and evaluate models, conduct research, and provide technical assistance to providers on removing language barriers to health care services." (Committee on Appropriations Report, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 1995, Report 103-553)

Scope of This Study

OMH has been specifically tasked [Pub. L. 101-527, section 1707(B)(7)]with instituting initiatives seeking to improve health care access for minority populations with limited English proficiency. In FY 1993, OMH developed and implemented the *Bilingual/Bicultural Service Demonstration Grant Program* under this authority. This program was designed to:

1. Provide bilingual/bicultural assistance in providing health services to designated populations (Asian, American Samoan, Native Hawaiian, Pacific Islander, Hispanic, American Indian, Alaskan Native, African, and Caribbean); and
2. Build the capacity of minority, limited English proficient (LEP), community-based organizations to increase access to health services.

The present study covers the first three series of grants (FY 1993-1995) under the Bilingual/Bicultural Service Demonstration Program, encompassing 62 projects, for a total value of $4.75 million. Awards are characterized in the table below. The Bilingual/Bicultural program, however, is ongoing, and has recently awarded funds for a new series of grants.

Bilingual/Bicultural Service Demonstration Grants Awarded

Fiscal Year	Number of Grants	Annual Value (per grant)	Geographic Locations
1993	12, one-year	$50,000	10 states & the District of Columbia
1994	35, one-year	$75,000	14 states & the District of Columbia
1995	15, three-year	$100,00	five states, the District of Columbia, & American Samoa

Exhibit 1-1 displays the location of grantees for each of the three years. This report is a direct response to Public Law 101-527 (*Disadvantaged Minority Health Improvement Act*), Section 1707 (D)(2), which requires OMH to "provide for evaluations of projects carried out with financial assistance provided under paragraph (1)." This report also responds to requests for the dissemination of information developed from such projects and for the inclusion of a report on such efforts in a broader **Biennial Report to Congress** (Section 1707 (E)).

More than simply a response to legislation, however, the study discussed in this report is a first attempt to gather comprehensive information about the implementation and impact of the OMH grant program. Prior to the current study, OMH did not have the opportunity to conduct a systematic review of their efforts to support linguistically appropriate and culturally sensitive health care services, or to document implementation of the OMH Bilingual/Bicultural demonstration grant program across all sites. This study directly addresses this gap. A description of the process by which the services were developed and implemented, and a review of their impacts, is a first step toward identification and replication of effective programs.

METHODOLOGY

The study has been carried out in two phases. Phase I involved the administration of a Mail Verification Survey and a Follow-up Telephone Interview to a sample of 32 of the 47 projects funded in FY 1993 and FY 1994. Phase II involved site visits to nine of the 15 FY 1995 (3-year) grantees. The site visits were intended to provide further in-depth data, to verify and explore patterns identified in Phase I, and to identify any impact and implementation differences in the longer term grants. Overall, the study aimed to collect data in response to the following eight policy and programmatic questions (called "domains"):

DOMAIN ONE: Did the program help build the capacity of community-based organizations to address access to health services for limited-English-speaking minority populations?

DOMAIN TWO: Did the program increase the capabilities of health care professionals to address cultural and linguistic barriers to effective health care service delivery?

DOMAIN THREE: Did the program increase access to health care for limited-English-speaking minority populations and their knowledge of and ability to negotiate the health care system?

DOMAIN FOUR: Did the program increase consumers' knowledge of preventive health?

DOMAIN FIVE: Did the program serve as a catalyst to develop or change existing health policies at the community level?

DOMAIN SIX: Did the program findings and/or outcomes influence State/Federal policies targeting limited-English-speaking minority populations?

DOMAIN SEVEN: Were specific methods of implementation more effective than others? What methods were most effective in creating and sustaining linkages between a project and other organizations within that community?

DOMAIN EIGHT: What are the main components of an effective program?

Development of Phase I Protocols

The Phase I protocols (Mail Verification Survey and Telephone Followup Interview) were developed through an extensive process that included ideas from an expert Advisory Committee as well as pilot testing. The Advisory Committee was composed of experts from a range of ethnic and organizational backgrounds reflecting the diversity of OMH grantees themselves:

- Vilay Chaleunrath, Executive Director, Indochinese Community Center (Washington, DC)
- Michelle Chino, Ph.D.,Director of the Division of Planning, Evaluation, Information, and Research, Albuquerque Area Indian Health Board, Inc. (Albuquerque, NM)
- Mary Anne Foo, Orange County Asian and Pacific Islander Community Alliance, (Garden Grove, CA)
- Maria S. Gomez, R.N., M.P.H.,Executive Director, Mary's Center for Maternal & Child Care, Inc. (Washington, DC)
- Ford H. Kuramoto, D.S.W., National Director, National Asian Pacific American Families Against Substance Abuse, Inc. (Monterey Park, CA)
- Alberto Mata, Ph.D., The University of Oklahoma/Department of Human Relations (Norman, OK)
- Howard H. Phengsomphone, Project Director, Southeast Asian Youth and Family Development Project (Providence, RI)
- Luis Szyfres, M.D., M.P.H., Former Chief, Division of Clinical/Program Evaluation and Research, Government of the District of Columbia, Department of Human Services, Addiction Prevention and Recovery Administration (Washington, DC)
- Sora Park Tanjasiri, Dr.P.H., Independent Consultant, Asian-American Health Program Development (Los Angeles, CA)
- Ruth Enid Zambrana, Ph.D., Director, Child Welfare Center, George Mason University Human Services Program (Fairfax, VA)

The Advisory Committee met on December 12 and 13, 1996, to review and comment on the Phase I Mail Verification Survey, Follow-up Telephone Interview, respondent advance letters, and general procedures—including: data elements to be collected, data collection strategies, issues of cultural appropriateness surrounding data collection, and potential problems/resolutions. Responses from this committee helped to ensure that the data collection protocols and procedures were both culturally competent and tailored to the circumstances characteristic of OMH grantees. The Advisory Committee then remained available to provide input throughout all phases of the study.

Once draft instruments were developed, incorporating Advisory Committee and OMH input, a pilot test of Phase I survey instruments was conducted at the following four grantee sites:

- Asian Americans for Community Involvement, Asian Seniors Health Project, San Jose, CA
- Breaking Down the Barriers, Southeast Asian Health Project, Long Beach, CA
- Dallas Multicultural Alliance, Bilingual Dental Access Coalition, Dallas, TX
- Vista Community Health Clinic, Vista, CA

These sites were asked to complete the Mail Verification Survey and the Follow-up Telephone Interview. They were also asked to comment on the process itself—any undue difficulties imposed, questions that were unclear, procedures that were particularly burdensome, and they were asked to make suggestions for improvement. Mail Verification Surveys were received from all four of the pilot test sites. Based on the pilot test, several changes were made in the instruments and process, and a final set of instruments was created (see **Appendix A: Phase One Instruments and Appendix B: Phase Two Instruments**). A finalized letter of introduction was signed by OMH Director Clay E. Simpson, Jr., MSPH, Ph.D., and mailed out immediately after OMB clearance. (**Appendix C: Letter of Introduction**).

Obtaining OMB Clearance

Because the survey was to be conducted with more than nine sites, clearance was required from the Office of Management and Budget (OMB) under the Paperwork Reduction Act. An OMB Clearance Package was submitted to OMH on June 17, 1997, for submission to OMB. The clearance process extended beyond the timeframes originally envisioned, and clearance was not received until December 24, 1997. Therefore, the Phase I data collection process began in January 1998, immediately following receipt of clearance.

Implementing the Phase I Survey

To speed data collection and to contain costs, a sample of 32 of the 47 Phase I grantees was selected for inclusion in the data collection. The sites were chosen to have maximum representation of ethnic/language group, region, and major focus of program activities (e.g., developing materials, conducting training, providing access to services). Three of the four previously-noted pilot test sites were included in the sample of 32; one pilot site's data was discarded due to discrepancies that could not be resolved because the grantee had gone out of business.

With the understanding that staff would have changed and that some FY 1993 and 1994 grantees would no longer exist, it was important to minimize problems resulting from inaccessible records or staff, and to reduce the burden on current staff who would have to complete the survey instrument. Therefore, as planned, DSG staff completed ("precoded") as much of the mail survey as possible before mailing, using project proposals and quarterly, final, and evaluation reports supplied by the OMH Project Officer. Sometimes, almost 70 percent of the required information could be precoded from these sources. Survey respondents were then asked to review the partially completed form for accuracy and supply as much of the missing information as possible. When grantees returned the mail survey, a followup telephone interview was scheduled and conducted. This interview was used to clarify incomplete or unclear survey responses, and to gather more qualitative information on the implementation of these projects. The mail survey and telephone follow-up interviews used during this phase were intended to provide critical information on program characteristics, the program implementation process, model program components, and common barriers faced by these programs. It also was intended to provide insight on the impact the programs had on their communities. An Interim Report was submitted to OMH on November 17, 1997, based on an analysis of trends and patterns identified from the precoding process.

Although the return rate for mail surveys was slow at first, an intensive effort was mounted to ultimately achieve a 93 percent response rate (completed mail surveys from 27 of the 29 non-pilot projects). In the final data analyses, DSG has used the precoded mail survey data for the two projects that did not return a mail survey. These data were taken from reports and information submitted to OMH by the projects as part of their regular reporting. The only difference is that they have not been reviewed and confirmed a second time by project staff. Completed followup telephone surveys were conducted with 26 projects. Of these, three telephone interviews were part of the pilot survey effort, and 22 telephone interviews were conducted with non-pilot survey projects.

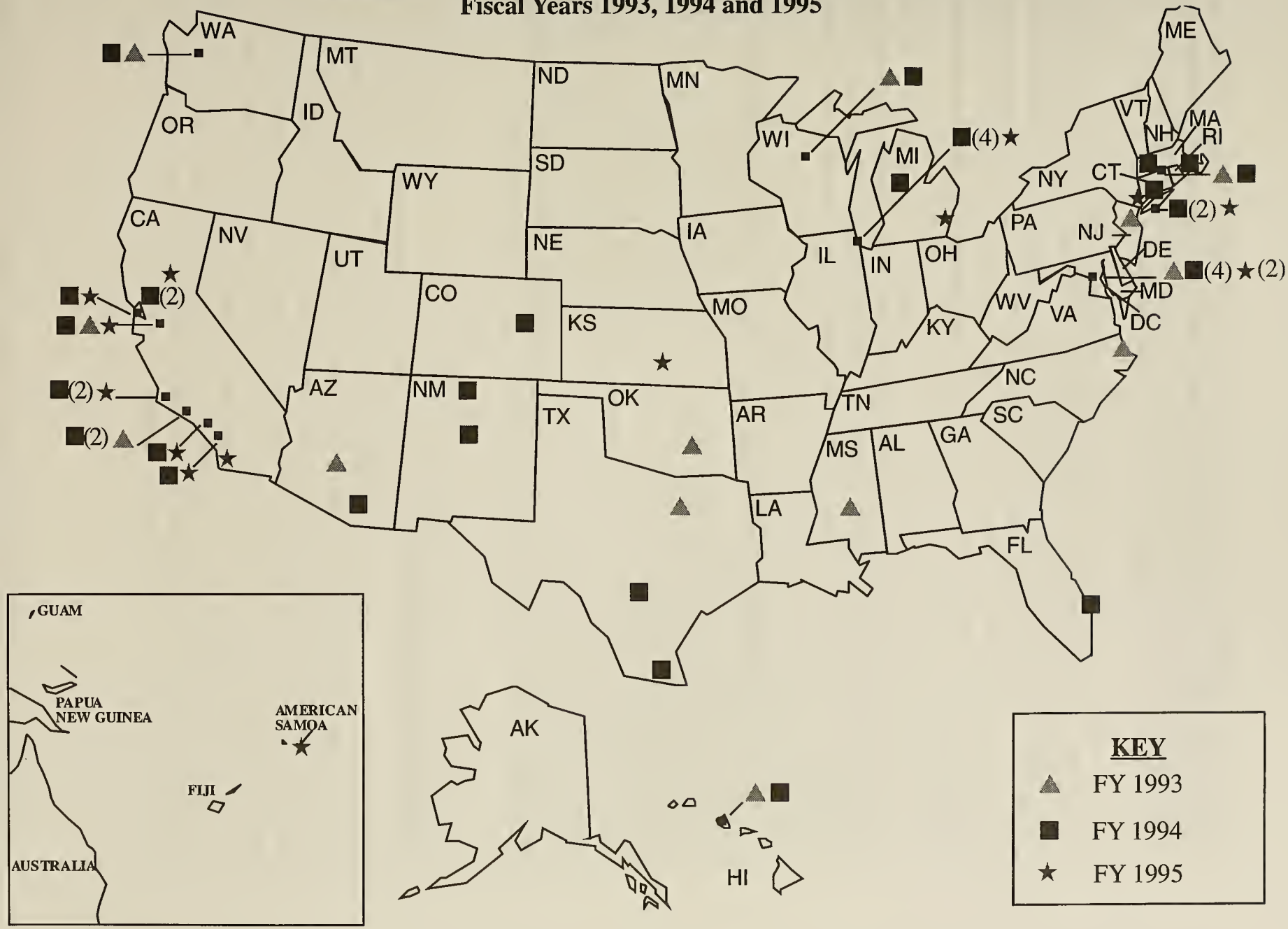
Phase II Site Visits

The Phase II process evolved from what was learned during Phase I, particularly with respect to trends on the nature of program activities, the need for impact data beyond what was collected in the evaluation, and other issues. Phase II included site visits to the following nine FY 1995 sites, selected to provide a balance of target population, region, and type of program service offered:

- African Services Committee, Inc.; New York, NY
- Asian Americans for Community Involvement, Inc.; San Jose, CA
- Asian and Pacific Islander Wellness Center; San Francisco, CA
- City of Chicago Department of Health; Chicago, IL
- La Clinica del Pueblo; Washington, DC
- St. Joseph's Hospital; New York, NY
- Union of Pan Asian Communities; San Diego, CA
- Vista Community Health Clinic; Vista, CA
- Wichita-Sedgwick County Department of Community Health; Wichita, KS

(For a complete list of all projects, see **Appendix D: List of OMH Bilingual/Bicultural Service Demonstration Projects.** A map of the location of all projects appears in **Exhibit 1-1.**)

Exhibit I-1
Geographic Distribution of OMH Bilingual/Bicultural Grantees
Fiscal Years 1993, 1994 and 1995



As described in the original proposal, site visit protocols were developed to include: (1) Interviews with the project director, key staff, health officials knowledgeable about the project, representatives from other services who had referral arrangements with the OMH project, and community leaders, and (2) Focus group interviews with project clients, where appropriate.

When possible, each site visit also included some observation of project activities and an introduction to the target community. The project director interview also was structured to provide data comparable to the Mail Verification Survey, across a subset of questions, so that a complete data set could be developed across both Phase I and II. Simultaneously, the interview format allowed for the collection of substantial qualitative data for each site—essential for replicating and expanding these types of service programs in the future. **Appendix B:** contains the site visit instruments used during Phase Two.

Each site visit was conducted using a two-person team, generally over two and one half to three days. The teams were either composed of Principal Investigator (PI) Frank Wong, Ph.D., and Co-Principal Investigator (Co-PI) Mark Edberg, or composed of the PI or Co-PI and a consultant with expertise in the target population. Site visit teams used in Phase II were as follows:

Site Name and Location	Site Visit Team
African Services Committee, Inc., New York, NY	Frank Wong and Mark Edberg
Asian Americans for Community Involvement, Inc. San Jose, CA	Frank Wong and Phillip Akutsu, Ph.D.
Asian and Pacific Islander Wellness Center; San Francisco, CA	Frank Wong and Phillip Akutsu, Ph.D.
City of Chicago Department of Health Chicago, IL	Frank Wong and Mark Edberg
La Clinica del Pueblo; Washington, DC	Mark Edberg and Sonia Rodriquez
St. Joseph's Hospital; New York, NY	Frank Wong and Marianne Yoshioka, D.S.W.
Union of Pan Asian Communities; San Diego, CA	Mark Edberg and Richard Kim, Ph.D.
Vista Community Health Clinic; Vista, CA	Mark Edberg and Joao Ferreira-Pinto, Ph.D.
Wichita-Sedgwick County Department of Community Health, Wichita, KS	Frank Wong and Mark Edberg

Site visit reports (case studies) were prepared combining notes/records of both team members.

IMPLEMENTATION OF THE STUDY

DSG encountered several problems in gathering data for the study. First, not all project proposals, quarterly reports, final reports, and materials created were available for DSG staff. This is not unusual, since all Phase I sample projects had been completed for several years. Nevertheless, the documentation obtained was enough for purposes of pre-coding. Second, grantee staff were frequently difficult to contact, for multiple reasons—some grantees moved, two grantees went out of business, several grantees lacked an answering service, and many grantee staff spent a lot of time in the field and were difficult to reach by phone. Finally, particularly for the FY 1993 grantees, sometimes all or most of the OMH project's staff had left, leaving to new employees the task of locating data and reconstructing their agency's experience with the project.

As mentioned earlier, a second obstacle encountered in the study was that OMB Clearance took longer to obtain than was anticipated. DSG submitted the OMB Clearance Package to OMH on June 17, 1997, but clearance was not received until December 24, 1997. Only then could the Phase I survey proceed. Given those obstacles, however, a substantial amount of study data was obtained.

PRESENTATION OF FINDINGS FROM THE STUDY

The remainder of this report is devoted to presentation of study findings, analyses, and recommendations.

In Chapters II and III, implementation and impact data are reported separately for Phase I and Phase II. The data are initially reported in separate sections because of key differences between Phase I (FY 1993-94) and Phase II (FY 1995) grantees. The major difference was that earlier grants had fewer resources and operated for a one-year period, while the Phase II grants were three-year projects. In addition, the research process, as described, was different for the two phases. In each case, however, we report descriptive data on the projects and their target populations, followed by a summary of data collected, by research "domain," as described earlier. In these two chapters, we concentrate on data in Domains One through Six, which are the actual data collection domains. Responses to Domains Seven and Eight are the result of analyses conducted on data in Domains One through Six.

In Chapter IV, we include: a summary of commonalities and differences between Phase I and II projects across Domains One through Six; common characteristics of grantees and the populations they served; major impacts, for FY 1993-94 and FY 1995 grants, and patterns with respect to impact; a review of most effective program components and types (Domains Seven and Eight); common implementation issues and barriers; and replicable strategies and materials.

Chapter V presents a set of program recommendations, based on the Phase I and II findings.

NOTE: *Throughout this report, we report all findings without individual or project identifying information. While this does result in a certain "loss of realism," it is necessary to maintain project and staff confidentiality while offering candid information.*

CHAPTER II

Phase One Results: Mail Survey and Telephone Follow-up

DESCRIPTION OF PHASE I GRANTEES

Funding and Project Locations

All FY 1993 and 1994 projects were originally funded for one year. Budgets for FY 1993 projects ranged from $49,439 to $50,000. The average award was $49,900. Budgets for FY 1994 projects ranged from $56,300 to 75,539, averaging $73,884. Eleven projects requested a formal no-cost extension—four of the FY 1993 projects and seven from FY 1994. Extensions were given most often for three months. Most projects provided in-kind matches, ranging from $5,000 to $54,999, with an average in-kind match in FY 1993 of $24,527 and in FY 1994, of $12,857. Additionally, six projects listed funding from other organizations ranging from $500 to $192,836. Nineteen of the projects (59%) engaged in partnerships. Many of these projects engaged in multiple partnerships. Of these 19 projects:

- 95% of the projects engaged in one or more partnerships of an informal nature,
- six partnerships (32%) had a formal Memoranda of Understanding, and
- six partnerships (32%) had a formal subcontract (subcontracts averaged just under $10,000).

The partnerships varied widely, most often with community health centers, hospitals, social service agencies, universities, HIV/AIDS programs, and health professionals or associations.

The 32 sampled grantees were located as follows: seven in California; three in the District of Columbia; two each in Illinois, Arizona, Connecticut, Hawaii, and Wisconsin; and one each in Washington, Mississippi, New Jersey, Colorado, Oklahoma, Michigan, New York, Virginia, New Mexico, Massachusetts, Florida, and Texas.

The vast majority of the projects (29, 91%) operated in urban locations. Another seven (22%) were located in rural areas and three (9%) in suburban areas. (Some projects located their activities in more than one area, so percentages do not equal 100%.) Nearly half of the 101 project activities implemented were neighborhood-wide, citywide, or county-wide (52%). Another 36% served multiple cities or counties, 6% served reservations, and for 7% of the projects, the target population was nationwide.

Grantee Types

Ninety-four percent of the sampled grantees were nonprofit organizations; two grantees were tribal governments. The funded projects operated out of a variety of settings, including community health and mental health centers, refugee assistance centers, multi-service and social service agencies, and tribal governments. In Phase I, twelve (38%) of the grants were awarded to community health centers; seven (22%) to refugee assistance centers; three (9%) to community mental health centers;

six (18%) to community-based organizations, prenatal and pediatric health care centers, or and advocacy/health and human services organizations; two grants (6%) were awarded to multi-service or social service agencies, and two (6%) were awarded to tribal governments.

Typically, the types of non-OMH activities engaged in by grantee organizations were as follows:

- Community health centers offered direct medical services, such as, prenatal, pediatric, adolescent, adult and geriatric care;
- Refugee assistance centers provided education, advocacy and counseling programs for immigrant groups, such as Cambodians or Indochinese;
- Community mental health centers provided outreach, child abuse prevention services, counseling, health promotion, HIV/AIDS outreach, and elderly programs;
- Other community-based organizations provided certain specific services, such as health promotion or AIDS education;
- Prenatal and pediatric health care centers provided bilingual pregnancy tests, family planning services, health education, basic care and nutrition, childbirth and delivery preparation, and parenting skills services for pregnant women and/or their families;
- Advocacy, education, and health/human services organizations often provided human services, education, community development, support and assistance to victims, and bilingual/bicultural programs to specific groups;
- Multi-service and social service agencies typically provided health education and prevention, employment and training, outreach, prevention and advocacy, drug treatment and other services; and
- Tribal governments provided a full range of services, including education for children and adults, Head Start, child care, and children's services.

Half the grantee organizations were founded in the 1970's, one-third in the 1980's, three had been founded in the 1960's, and three more recently in the 1990's. Eleven grantees (40%) had annual budgets of less than $2 million; ten grantees (36%) had budgets from $2 to $4 million, and seven grantees (25%) had budgets of $4 million or more.

Project Focus and Major Activities

The focus of Bilingual/Bicultural projects spanned more than 17 primary health issues included the National Health Goals for the Year 2000. These health issues were addressed through several strategies: increasing awareness about the issue (including prevention and treatment), increasing provider capabilities to work with specific LEP populations, and providing access to specific medical/health services, e.g., through case management, interpretation, health screenings and referrals, and other methods. The most frequently addressed health concerns included:

- maternal and infant health (31%),
- access to general services addressing a variety of health care needs (28%),
- sexually transmitted diseases (28%),
- access to family planning services (25%),
- HIV/AIDS (25%),
- immunization (22%), and
- infectious disease (22%).

Most of the Bilingual/Bicultural projects undertook activities in several areas:

- Thirty-one (97%) provided training,
- Twenty -eight (88%) provided materials development and dissemination, and
- Sixteen (50%) focused on providing increased access to services.

Most grantees undertook activities in more than one of the three broad categories, seventeen (55%) had activities in two categories and thirteen (41%) performed activities in all three categories. When asked to report on the primary focus of project activities:

- Twenty-five(78%) reported training or education for either LEP population or health and social service staff;
- Fifteen (47%) reported services[1] to the LEP population (for example, health screenings or case management);
- Twelve (38%) reported developing and/or disseminating health promotion information or materials; and
- One each said conducting needs assessments and bilingual community outreach.

Details about services appear in the section on findings by domain later in this chapter.

TARGET POPULATION

Income/Employment Levels and Language Ability

Over three-quarters (77%) of the projects served target populations with low income levels; the remainder served mixed or middle income levels. Of the 15 projects responding to a question regarding unemployment, three projects served target populations with 71% to 100% unemployment levels; five projects served target populations with unemployment levels from 31-50%; and seven served target populations with unemployment levels from 11 to 30%.

Based on the 19 projects that answered this question, eight served target populations in which 80 to 100% of the residents had limited or no English-speaking ability, five served target populations which were between 60 to 79% LEP, two served LEP populations of 40 to 59%, and four served LEP populations between 10 to 29%.

Target Population Compared with Community in Which Projects Were Located

In general, the target populations were disadvantaged along with their communities. Of 24 projects responding, fourteen (58%) reported a low income level in the general population; seven (29%) reported mixed income levels; and three (13%) middle income levels. Compared to the target population, 17 of the projects served similar income levels, six served populations with incomes lower than the general population, and one served income levels higher than the general population.

[1] Access or enabling services.

Of the 13 projects that reported unemployment level, three reported from 51 to 80% unemployed, three from 31 to 50% unemployed, and seven from 1 to 20 percent unemployed. Compared to the target population, six of the projects had target populations whose unemployment percentage was higher than the general population, four had lower unemployment levels, and two had similar unemployment rates.

Of the 15 projects responding, eight had general populations from 1 to 29% LEP, seven projects has general populations that were from 70 to 99% LEP. When comparing the target population's English-speaking ability to that of the general population, six projects had percentages higher for the target population, five had percentages the same, and four had percentages which were lower.

Ethnic Groups Served and Languages Spoken

Asian peoples made up the broad ethnic category most frequently served by all projects—eighteen (56%), followed by Hispanic/Latinos, thirteen (41%), Pacific Islanders—three (9%), American Indians—two (6%), and Africans— one (3%) (see **Table 2-1**). There were more than 14 specific ethnic groups served in the Asian category, most frequently Cambodian/Khmer, Laotian, and Vietnamese. Mexicans, Central Americans, and Salvadorans were the groups most frequently served among Hispanic/Latino populations.

More than 22 languages were spoken by the target populations served (see **Table 2-2**). Most frequently these were Spanish (41%), Lao (38%), Vietnamese (38%), Khmer (31%), Hmong (22%), Chinese (19%), Thai (19%), and Tagalog (13%).

Age and Special Characteristics

Two-thirds of the grantees served target populations of all ages (adults and children); 29% served adults only; and 7% served minors only. Nearly two-thirds reported no special characteristics for the target population served; however, among those that did, women at risk of HIV, pregnant women and teens were the most frequently targeted group, followed by men who have sex with men and families of infants.

PROJECT STAFFING AND STAFF RETENTION

For more than two-thirds of the projects, the OMH-funded activities were new to the grantee; for the remainder, the activities were an expansion of existing grantee activities. The vast majority of projects did not co-locate their project activities with another provider and offered OMH-funded services only through their main office. An average of 1.6 FTE (full-time equivalent) positions were filled using OMH funding. An average of three staff members were used to fill these positions. More than half of the projects used consultants to provide project services as well. More than four-fifths of the projects reported using a mixture of existing and new staff to provide OMH-funded activities. All projects used staff who reflected the ethnic makeup of the target LEP participants. All but one project reported using staff who spoke the primary language of the LEP clients (that project used a consultant where this was necessary).

Table 2-1
Ethnic Groups Served, (Phase I Grantee Sample)

Ethnic Group	Number of Projects Serving This Group	Percent of Projects Serving This Group*
ASIAN	**18**	**56%**
Cambodian/Khmer	12	38%
Chinese	6	19%
Filipino	4	13%
Hmong	7	22%
Japanese	2	6%
Korean	3	9%
Laotian	12	38%
Mien	2	6%
Thai	3	9%
Vietnamese	12	38%
Malaysian	1	3%
Indonesian	1	3%
Amerasian	1	3%
Other Asian	1	3%
HISPANIC/LATINO	**13**	**41%**
Central American	3	9%
Guatemalan	2	6%
Mayan	2	6%
Honduran	1	3%
Nicaraguan	2	6%
Salvadoran	3	9%
Other Central American	2	6%
Cuban	1	3%
Dominican	1	3%
Mexican	6	19%
Puerto Rican	2	6%
South American	1	3%
Spanish	1	3%
***PACIFIC ISLANDER** (Samoan)*	**3**	**9%**
AMERICAN INDIAN	**2**	**6%**
Choctaw	1	3%
Cherokee	1	3%
African**	**1**	**3%**

*Projects served more than one ethnic group, therefore column totals exceed 100%
**This project did not specify an African ethnic group

Table 2-2
Language Groups Served, (Phase I Grantee Sample)

Language	Number of Projects Serving Speakers of this Language	Percent of Projects Serving Speakers of this Language*
Spanish	13	41%
Lao	12	38%
Vietnamese	12	38%
Khmer (Cambodia)	10	31%
Hmong (Laos, Cambodia)	7	22%
Chinese	6	19%
Mandarin Chinese	4	13%
Cantonese	6	19%
Other Chinese Dialects	1	3%
Thai	6	19%
Tagalog (Phillippines)	4	13%
Taiwanese	3	9%
Ilocano (Phillippines)	3	9%
Korean	3	9%
Visayan (Phillippines)	2	6%
Japanese	2	6%
Samoan	2	6%
Choctaw (Native American)	1	3%
Mien (Laos)	1	3%
Cherokee (Native American)	1	3%
Malaysian	1	3%
Indonesian	1	3%
Kanjobal (Guatemala, Mexico)	1	3%
Jacalteo (Guatemala)	1	3%
Mam (Mexico, Northern and Central South America)	1	3%

*Projects served multiple language groups, therefore column totals exceed 100%.

More than half (53.3%) of the projects reported that project staff needed additional training to carry out project activities. Most often, this training was related to the project health issue(s), for example, HIV/AIDS, teen pregnancy, sexuality information, smoking cessation, substance and alcohol abuse,

heart disease, domestic violence and related health issues. In addition, many projects provided staff training in confidentiality, medical terminology, ethical issues, curriculum development, community resources, and child development.

Over half of the projects responding to this question (fifteen projects, 56%) reported that there was turnover among OMH-project staff. Nine projects had one person leave during the grant period, five projects had two leave, and one had three leave. The most frequent reasons for staff turnover cited by the 15 projects were that staff found better career opportunities or wanted a career change; staff returned to school for further education; there was a poor fit between the staff person and the job, or the person's English-language skills were inadequate. The issue of staff retention is clearly one that must be addressed in ongoing efforts to improve the Bilingual/Bicultural program as a whole.

More than four-fifths of the projects (83%) felt that burnout was not an issue for OMH staff. For the five projects that reported burnout as an issue, the most frequent cause cited was the part-time nature of the job, which put a great deal of strain on staff, and difficulty with scheduling. In addition, caseloads were high and stressful for workers. More than half of the projects (57%) used volunteers to carry out OMH activities. Among those using volunteers, half used five or fewer volunteers, and half used more than five. One project used up to sixty volunteers.

PROJECT NEEDS ASSESSMENTS

Nine projects (28%) conducted needs assessments as part of their grant activities (above and beyond the customary practice of using existing needs data to "make a case" in the grant application). Of those that did, seven of the nine were conducted after the grant was awarded. The most frequently employed methodologies in the needs assessments were surveys (six projects), interviews with key informants (four projects), focus groups (three projects), meetings (two projects), and literature searches or local/state reports (two projects). Some projects used more than one methodology. Most needs assessments did not address specific illnesses or health conditions but rather, looked at:

- the cultural/linguistic training needs for health provider staff (five projects),
- barriers to accessing health care for the target population (four projects),
- existence of culturally/linguistically competent health services (four projects),
- target population health behavior or knowledge/awareness (four projects), and
- the existence of culturally/linguistically appropriate health education materials (three projects).

Key needs assessment findings revealed that the communities in question had no curriculum for training Southeast Asian interpreters on mental health issues. The needs assessments also revealed that there was a lack of understanding by health providers of the needs of new arrivals and that new arrivals had insufficient income and lacked transportation, health coverage, and/or a primary provider. Widespread exposure to HIV infection was detected in some populations.

Most frequently, projects addressed gaps by developing curricula, addressing AIDS/HIV risk and exposure through services and outreach, providing training in cultural competence, and educating patients about services available at clinics and in emergency rooms.

With respect to accessing health services, projects identified more than a dozen barriers facing the target populations. Most frequently cited were:

- language/lack of translation materials and lack of language-appropriate information, signs or brochures, thirty projects (94%),
- lack of awareness among target population, twenty-five projects (78%),
- gaps between the target population's health practices and mainstream health practices, nineteen projects (60%),
- lack of health insurance or other benefits to cover costs, seventeen projects (53%),
- lack of money, seventeen (53%), and
- lack of awareness among providers, sixteen (50%) (see **Table 2-3**).

Table 2-3
Barriers to Health Care for Groups Served, (Phase I Grantee Sample)

BARRIERS	No. of Projects Reporting These Barriers	Percent of Projects Reporting These Barriers*
Language/lack of translation materials/lack of language-appropriate information, signs, brochures	30	94%
Lack of awareness among target population	25	78%
Other barriers (waiting time, no health education in schools, inconvenient clinic hours, no child care facilities at clinic)	21	66%
Gap between target population health practices and mainstream health practices	19	60%
Lack of health insurance/other benefits to cover costs	17	53%
Lack of money to access services, transportation, etc.	17	53%
Lack of bilingual/bicultural awareness among providers	16	50%
Lack of culturally appropriate health education materials	14	44%
Education level of LEP members	14	44%
Transportation/geographic access	12	38%
Lack of available services	11	34%
Psychological problems, i.e. depression, substance abuse	4	13%
Population hasn't been studied enough	2	6%

* Projects reported multiple barriers to health care, therefore column total exceeds 100%.

GOALS AND OBJECTIVES

Goals establish the overall direction of a bilingual/bicultural service demonstration grant and, with accompanying objectives, constitute the criteria against which a project can be evaluated. Without well-conceived goals and objectives and data on their achievement level, even the best projects cannot effectively serve their constituencies. With one-year grants, this is a critical issue because of the short timeframe and limited resources.

FY 1993-94 projects identified an average of three goals and seven objectives each, for a total of 90 goals and 235 objectives. There was wide variation on the number of project goals and objectives. Some projects proposed many more than others, with one project recording 14 goals and another 20 objectives. These goals and objectives were categorized into eight types:

- education and training—37%,
- materials development and/or dissemination—30%,
- service delivery—21%,
- capacity building—14%,
- needs assessment—6%,
- outreach—5%,
- process objectives—4%, and
- community impact/policy change—1%.

The vast majority of objectives remained the same throughout the project—28 objectives (12%) were revised or created later. As will be discussed later in this report, high numbers of goals and objectives became problematic for these short-term (one year) grants. (see mail survey in **Appendix A** for definitions of these categories)

Seventy-eight percent of the projects fully achieved more than half of their objectives; 28% partially achieved more than half of their objectives. Seventy-eight percent of the projects fully or partially achieved 80% or more of their objectives.

Out of all objectives, one hundred fifty-six (66%) were fully achieved; sixty (26%) were partially achieved, twelve (5%) were not achieved, and seven objectives (3%) were not measured. **Exhibit 2-1** shows the achievement level by type of objective for the Phase I sample of grantees. It shows that (FY 1993 and 1994) projects were more successful in fully achieving objectives that involved capacity building and the development and dissemination of materials than in achieving those that involved education and training and service delivery.

Exhibit 2-1
Achievement Level by Type of Objective
(Phase I Grantee Sample)

Type of Objective	Number of Objectives	Achievement Level		
		Fully Achieved	Partially Achieved	Not Achieved
Education & training	81	47 (60%)	30 (37%)	4 (5%)
Materials develop/dissemination	64	55 (86%)	7 (11%)	2 (3%)
Service delivery	47	28 (60%)	13 (28%)	6 (13%)
Capacity building	33	25 (76%)	7 (21%)	1 (3%)
Needs assessment	12	11 (92%)	--	1 (9%)
Outreach	11	8 (73%)	3 (27%)	---
Process	9	9 (100%)	---	---
Community impact/policy change	2	2 (100%)	---	---

Note: Seven objectives were excluded from this table because their achievement level is not known

FINDINGS BY DOMAIN

Domain 1: Building the Capacity of CBOs to Address Access to Health Services for LEP Minority Populations

One of the functions of Federal funding for community programs is to give organizations the opportunity to expand and develop their capacity to respond to problems on a local level. With respect to the OMH Bilingual/Bicultural program for LEP minority populations, the hope was that the grantees would be able to use the grant funding to increase organizational and community capacity to provide culturally competent medical care to these populations. During the evaluation, the 1993 and 1994 grantees were asked about capacity development in five different areas: generating additional funding to supplement OMH funds, continuation of grant activities beyond the period of OMH support, development of new organizational policies/procedures as a result of the project, expansion of community-level coalitions, and integration of project activities into additional programs or organizations. Given the limited one-year time-frame of these projects, they were reasonably successful in increasing the grantee organizations' ability to address health care for LEP minority populations.

Additional Funding

Nineteen percent of the 1993 and 1994 grantees sampled were able to generate additional funds during the project period to supplement OMH support in carrying out their project's activities. The amounts of additional funding tended to be relatively small, with one exception. Additional support for projects ranged from $5,000 to $35,000, with the latter figure a clear outlier.

Project Continuation

Over half the grantees reported that the activities developed with OMH funds were continued beyond OMH funding and thus, served as ongoing resources for their local communities. This is a very important testament to the way in which even small projects responded to clear needs. Funding and other resources to continue project activities came from several different sources, including state health departments, local medical centers, local governments and private organizations.

Grantee Policy/Procedure Development

Nineteen percent of the grantees surveyed reported that they had adopted specific policies or procedures as a direct result of OMH grant activities. The new policies/procedures adopted by those organizations included:

- requiring staff training, developing long term plans for integrating cultural competency into all aspects of the organization,
- developing a culturally acceptable tribal plan for the long-term delivery of HIV/AIDS and related health risk factor education, and
- establishing the procedure that all emergency-room referred clients receive a clinic reminder call for follow-up treatments.

Specific examples from grantees include:

- One youth center incorporated the training developed under the grant as mandatory for incoming staff.
- Staff education around homophobia is now being required at one facility.
- Awareness of the need for intensive chronic disease management has improved among health providers in the area served by one grantee. New flowsheets were developed as a result of project activities. The medical providers now refer patients with chronic illnesses to the "ayudantes" for followup care.
- A three-year plan for further integration of cultural competency principles into one provider organization will be put into action. The plan is broadly based and is designed to address issues concerning the organizational environment, public relations, human resources, and clinical practice.
- Data generated from community groups during one project were used to develop a culturally acceptable tribal plan for the long-term delivery of HIV/AIDS and related health risk education. In addition, the bilingual education approach has been adopted by the local Community Health Education Department to develop additional teaching and prevention materials in the tribal *spoken* (oral) language for a variety of health concerns.
- Because of one grantee's work, all emergency-room referred clients receive a clinic reminder call for follow-up treatments.

Community Coalitions

Twenty-eight percent of the grantees sampled reported that either their organization or staff from their organization became involved in community coalitions or committees as a result of the OMH project. These activities were formal for some projects, while for others, the networking was more informal. Such participation can increase the awareness of the particular medical needs of LEP populations in the wider community. Specific examples provided by grantees include:

- There has been more collaboration with mainstream health organizations around health promotion issues. Related to breast cancer screening,/prevention, we collaborated with the American Cancer Society. We do a lot of promotion and help to do outreach to Asian women to have mammograms. We started because of the OMH grant. The coalition is informal and does not have a name.
- The Project Director is participating in the California Department of Health Services cultural and linguistic standards task force for managed care. They are helping to propose guidelines and recommendations for cultural competence. Other organizations that are members of the task force are managed care companies, advocates, and providers.
- There is a youth coalition that makes policy about all the things that need to happen when serving people under 18. This coalition did not exist before the grant and got going during the time of the OMH grant. It was not the only force that led to it being created, but the grant did contribute to its creation. The Oklahoma Council on Children and Youth is another statewide coalition. It oversees legislative policies and there is also a small grant fund coming through that organization for youth activities. We joined this coalition during the grant period, in part because of the grant.
- The organization facilitated a culturally competent community health care coalition for the population. It provided a support system for the target population by building a collaborative relationship with the Health Department and St. Lawrence Hospital. The hospital and the Health Department are primary sources for preventive health care providers for Hmong refugees. Direct services for referrals, interpretation and translation needs are there, readily available for all Hmong and Lao refugees.
- An important outcome of this project was the organization's increased visibility and credibility in the local Southeast Asian community, achieved through constant staff outreach, particularly the large-scale information dissemination. The most obvious result of this process was our successful launching of a Southeast Asian health coalition in the area last spring.
- A significant amount of informal networking was done. The project was able to network and form alliances with other Southeast Asian groups outside California. The project increased networking among different health care sectors, such as health departments working with local community leaders, social services, and mental health providers working with education and community leaders. The Atlanta training facilitated networking among the local health department programs and local organizations. In the training evaluation forms for some trainings, several organizations and health officials indicated that they would begin networking much more with leaders to improve access to care for the community. Finally, ties were strengthened with several California Southeast Asian organizations and can focus upon collaborative efforts in the future. We may be able to help facilitate a national Southeast Asian Health Network from the numerous visits and contacts made to Southeast Asian organizations nationally.

Integration of Project Activities

Thirty-one percent of grantees sampled reported that as a result of OMH funding, activities developed during the grant project had been integrated into other programs. For some, this meant that curricula developed with OMH funding continued to be used and was adopted by other organizations in the community. Staff training continued in some sites. In other sites, the use of translation services increased for hospitals and health care providers. Examples of the integration of project activities developed by OMH grantees include:

- After the curriculum was finalized, it was incorporated into our consultation and education (C&E) program. C&E and mental health staff gained knowledge in cultural competency in mental health interpretation. Staff provide training to new staff and staff of other organizations, using this curriculum.
- Major hospitals in the metro area started using professional medical interpreting for their patients. Volume has increased dramatically.
- Any time there is a language barrier, an interpreter is now requested (from International Institute).
- We have accepted referrals from a home health agency and from another clinic. These organizations give us referrals because we now have the capacity to take them, and we've been around a while so other organizations know about us now. We've also gotten referrals from the local health department.
- An instructional video about HIV prevention was developed to be used regularly over the tribal TV station which reaches the majority of homes in and around the county.
- Some of the activities have been integrated into some HIV/AIDS prevention programs targeting women.
- Cultural training for service providers continues at the medical center. They also incorporate this into orientation. Signs in the hospital are in multiple languages. They use the project for translation services.

Domain 2: Increase the Capabilities of Health Care Professionals to Address Cultural and Linguistic Barriers to Health Care

Training for Health Care Workers

Just over three-quarters of the sampled projects (78%) conducted trainings for health care workers on how to more effectively serve the target population. The 32 projects sampled conducted a total of 73 distinct types of training programs; of these, 32 (44%) trained health care workers on more effectively serving the target population. (Several projects conducted more than one type of training program.) Altogether, these 25 projects used 32 types of training programs for health care workers and trained at least 2,565 health care workers. The exact number trained is somewhat higher than 2,565, because the number of people trained was not reported for four of the training programs. **Table 2-4** shows the number of health care workers trained by the projects' target populations' major ethnic groups.

As **Table 2-5** shows, the 32 training programs served many different types of health care providers. The most commonly trained professionals included doctors, nurses, and community health workers. Other health care workers who were trained included health educators, outreach workers, physicians'

assistants, interpreters, midwives, case managers, emergency room staff, and many other types of health care workers.

Table 2-4
Number of Health Care Workers Trained
(Phase I Grantee Sample)

Projects' Target Population (Major Ethnic Group Categories)	Number of Health Care Workers Trained by Projects Serving this Target Population*
Asian	1,198
Hispanic	835
Asian and Pacific Islander	208
All ethnic groups served	164
Native American	131
Asian and Hispanic	29
Total	**2,565**

*Note: The actual number of health care workers trained is higher than 2,565, since for four types of training for health care workers, the number of people trained was not reported.

Table 2-5
Audience for Health Care Worker Trainings
(Phase I Grantee Sample)

Target Audience of Training	Number of Health Care Worker Trainings for the Target Audience
Other (see note)	24
Community health workers	14
Nurses/nurse practitioners	12
Physicians	11
Health educators	7
Outreach workers	7
Physician's assistants	5
Interpreters	3
Midwives	3
Case managers	2
Emergency room staff	2

Note: "Other type of audience" included: support staff, law enforcement, English as a Second Language Instructors, people who want to become home health care workers, staff members of community agencies, and other miscellaneous categories of audience members.

As **Table 2-6** shows, of the 32 training programs, 24 were provided by the grantee, four were provided by a collaborating organization, and three were provided by the grantee and a collaborating organization working as a team. In addition, for 22 training programs, the trainers' ethnicity reflected the ethnic makeup of the LEP target population, while in six programs, the trainers' ethnicity did not reflect the ethnic makeup of the LEP target population.

Table 2-6
Type of Organization Providing Training*, (Phase I Grantee Sample)

Type of Organization Providing Training	Number of Trainings	Percentage of Trainings
Grantee	24	77%
Collaborator	4	13%
Grantee and collaborator	3	10%

*For one type of training, this question was not answered; therefore, this type of training was not included in the table.

In half of the training programs for health care workers, the grantee developed the curriculum; for seven programs, the grantee obtained the curriculum; for four programs, the grantee adapted the curriculum from an existing curriculum; for one program, the grantee used two curricula, one of which was obtained and the other of which was adapted from an existing curriculum; and for one program, the grantee did not use a formal curriculum.

Twenty-three of the training programs for health care workers reported the average number of hours of training. For these programs, the median number of hours of training was three, the mean number of hours offered was 28, the range varied from two to 200 hours. Most trainings were from two to four hours long. Few trainings were intensive, however, those that were ranged from 95 to 200 hours. A 160 hour cultural competency training for health care students and a 200 hour training to help medical students pass licensure exams were the longest. A majority of the projects used a combination of teaching methods, including lecture, small group interaction, and video.

"We (also) trained the mainstream medical providers. The trainings raised to the forefront of the debate about how medical interpretation should occur. Some medical providers think that verbatim translation is best, but they don't realize that interpreters can be cultural experts as well. This became a healthy debate and forum for people to start addressing these issues. The grant also helped to empower the interpreters to speak up on behalf of the client"

"In the Physician Review Program, we've had over 25 physicians placed in internships throughout Chicago and many more physicians have gone through the program. This program has really helped the organization with its own recruitment of bilingual/bicultural providers. That's why we're very committed to this program and are still doing this program to this day."

"Now it is easier for patients to see a doctor, since more doctors now have a better understanding of Hmong culture. For example, now doctors understand that when they give forms to fill out to a Hmong wife, she will take the forms back to her husband for him to authorize them."

Twenty-four of the training programs for health care providers were evaluated. In these evaluations, the general practice was to administer a one-time assessment (pretest only, post-test only or pre- and post-test). One Hispanic-focused project had both an experimental group and a control group in its evaluation. Impact evaluations were conducted by two projects -- one Asian/Pacific Islander (API) project used a 3-month follow-up and one Hispanic focused project used a one-year follow-up. As an indicator for the effectiveness of the training, two projects (one API focused and one Hispanic focused) used the number of successful cases among trainees (interns and new medical/health care professionals) to secure state or licensing board certification.

Other Types of Training

Some grantees conducted types of training that do not fit neatly into the major categories of training for health care workers or training for the target population. Of the 73 training programs, six fell into this category. **Table 2-7** provides descriptions for each of these training programs, and the number of people trained. Four of the six involved some form of training for interpreters. The total number of people trained for all six types of training put together is 178.

Table 2-7
Additional Trainings Identified as Miscellaneous
(Phase I Grantee Sample)

Type of Training Provided by Grantee	Audience Which Received the Training	Number of People Trained
How to use multi-language handbook that grantee had created	target LEP population and health care workers	84
Training for interpreters	interpreters	28
Medical interpreter training	community health workers, outreach workers, interpreters, and bilingual volunteers	26
Training of trainers on how to teach smoking cessation classes	staff members from a social service organization	20
Training people how to become interpreters	bilingual volunteers	10
Training for interpreters, concentrated in areas of mental health issues and approaches; family issues; substance abuse; and HIV education	interpreters	10
Total Number of People Trained		178

Note: Each row above corresponds to one type of training. Each type of training was carried out by a different project (although two of the types of training were carried out by the same grantee in different years).

Materials for Health Care Workers

As mentioned previously, the 32 projects developed and/or adapted a total of at least 108 distinct types of materials. However, for many materials it is not possible to determine the audience. For example, some grantees created pamphlets but did not describe the pamphlets, and therefore the audience is not known. To give another example, of the 108 types of materials, 16 types were radio shows and three types were radio hotlines. For these radio shows and hotlines, the audience could have included both health care workers and other populations.

This section will describe characteristics of materials for audiences of health care workers, and then describe characteristics of materials for audiences that may have included health care workers.

Table 2-8 shows the types of materials created for health care workers, and **Table 2-9** shows the types of materials that may have had health care workers as part of their audience.

Table 2-8
Number and Types of Materials for Health Care Workers
(Phase I Grantee Sample)

Material Type	Number of Different Materials
Curriculum	10
Videos	2
Cultural competency manual	1
Pamphlets	1
Resource directory	1
Training manual for training grantee's community health workers	1
Total	16

Table 2-9
Other Types of Materials for Health Care Workers
(Phase I Grantee Sample)

Material Type	Number of Different Materials
Radio spots	16
Videos	12
Directory of health care and/or social service providers	3
Pamphlets	3
Radio hotlines	3
Audio tape	2
Curriculum	2
Newsletters	1
Posters	1
Protocol for using health mentors in clinics	1
Total	44

Overall, these data were not clear indicators of the direct or "unique" impact of health care worker trainings and/or materials on effective health care service delivery.[2] However, qualitative data indicated important effects in many areas. Several projects reported increased awareness by doctors/medical professionals, and the resultant increase in ability to work with language minorities. In one project, staff education on homophobia became a requirement. Also, one project reported that the Youth Services Screening Committee made staff training mandatory for incoming staff.

Domain 3: Increase Access to Health Care for LEP Minority Populations and Their Knowledge of/Ability to Negotiate the Health Care System

Of the 32 OMH projects, sixteen (50%) projects provided access to services for the LEP target population(s). The total number of distinct services provided by all projects combined was 38.[3] The mean number of types of services accessed per project was 1.2. The range was from zero to six types. Two projects offered five types of services, and one project offered six types. For example, one project provided Hispanic adults with case management, health screening, informal health promotion, an exercise program, and transportation.[4]

Several strategies were used by the projects to increase access to effective health care for LEP minority populations and to increase their knowledge concerning the health care system. **Table 2-10** presents results of mechanisms used to recruit clients into the projects as a "brokering point" for using direct medical services. Specifically, out of 16 projects that provided access to services, eleven (79%) projects had eligibility criteria (the most common one was LEP) for client participation, three (21%) did not, and two were unknown. All 16 projects (100%) provided services in the language(s) of the LEP target population(s). Nine (64%) projects stated that clients were involved in project activities more than three times; five projects (36%) stated that clients were involved "several times." **Table 2-11** shows the average duration that clients were involved with projects. In 36% of the projects, clients were involved with the project for over 60 days; 14% reported client involvement between 31 and 60 days; and 14% reported client involvement of 0 to 7 days. In the remainder of the projects, the length of involvement depended on the needs of the individual clients.

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2 There are a multitude of factors which can improve health care services delivery, including provider training.

3 When we say the projects provided "services," this refers to services (such as case management, interpretation) that "move" a client into direct medical services in some way.

4 When projects report providing numerous services such as these, there is some question about whether all services were funded by OMH or whether some are supported by other funding sources as well ("mingling" of funds). Project service data received from grantees was not always separated clearly by funding source.

Table 2-10
Strategies that Grantees Used to Recruit Clients for OMH Grant Services
(Phase I Grantee Sample)

Recruitment Strategy	Frequency	Percentage*
Outreach	13	81%
Referral	9	56%
Word of mouth	8	50%
Flyers or pamphlets	7	44%
Radio or television announcements	7	44%
Walk-in	6	38%
Other:	8	50%
The outreach workers were community members, they were already aware of people requiring help	1	6%
Recruiting clients who were already receiving other services from a particular grantee	1	6%
Door-to-door canvassing; group presentations; posters	1	6%
Existing clinic patients	1	6%
Health fairs, advertisement in a quarterly Laotian newspaper, and advertisement in the Hispanic Yellow Pages	1	6%
Press releases; health project staff made speeches about project at Asian community centers, churches, cultural festivals, apartment complexes, and fairs	1	6%
Promotional meetings	1	6%
Screenings/health lectures, festivals, health fairs, and press releases	1	6%

*Projects used multiple methods of recruitment, therefore column totals exceed 100%
Note: One project did not answer this question and therefore, data is not included in this table.

Table 2-11
Duration of LEP Target Population Client Involvement with OMH Projects
(Phase I Grantee Sample)

Duration of Client Involvement with Project	Number of Projects	Percent of Projects
Over 60 days	5	36%
0-7 days	2	14%
31-60 days	2	14%
Services continued as long as client still qualified by grantee	2	14%
15-30, 31-60, over 60 days depending on the services provided	1	7%
Dependent upon client's needs	1	7%
Continuous as needed	1	7%

Note: For two projects, this question was not answered, and therefore their data is not included in the table above.

Table 2-12 presents the types of service rendered by the projects. Note again that the OMH projects did not provide medical services per se, but *services/activities that moved clients into direct medical services, or otherwise facilitated access. This is what is referred to by project "services."* As can be seen, *case management* was the most common service provided by the projects. All 38 types of service were directly provided by the projects; no services were provided by subcontractors or other organizations. An estimate of 6,700 people received some type of service. In general, when projects provided multiple types of services, they tended to offer them to the same clients—for example, a project might offer case management, transportation, and health screenings to the same clients. (By contrast, when projects provided multiple types of training, they tended to offer them to different individuals.)

"We provide bilingual/bicultural staff to help facilitate and conduct the health screening lectures. We can see the impact. A lot of seniors really want to participate and they don't just participate one time--they attend multiple screenings. And we can see the changes, they have more confidence in terms of asking for information and getting help."

"It helped to make general health services available to people who are recent immigrants and have English as a second language. It has made the immigrant population more aware of preventive health. We have seen an increase in minority people coming in regularly for perinatal checkups."

Of the 38 types of services provided, 15 served as many people as planned and nine served less. For 14 types of service it cannot be determined if the original service level goal had been achieved. Thirteen of these types of service were not available before the OMH-funded project, two were available in a limited capacity, and four were available before the OMH project.

Table 2-12
Access Services Provided by OMH Projects
(Phase I Grantee Sample)

Type of Service	Number of Projects	Percent of Projects
Case management	10	26%
Limited case management	3	8%
Access to family planning	3	8%
Health screening	3	8%
Interpretation	3	8%
Transportation	3	8%
Developmental assessment/testing	2	5%
Primary pediatric care	2	5%
Translation	2	5%
Exercise program	1	3%
Home visits	1	3%
Access to Immunization	1	3%
Individual health counseling sessions	1	3%
Informal health promotion	1	3%
Informal peer HIV counseling	1	3%
Link teens to school	1	3%

A total of twenty-three (72%) projects responding providing training for LEP populations. [For clarification, note that the term "training," as it applies to LEP populations, includes all activities designed to impart information (other than dissemination of materials), including workshops, health fairs, educational, and similar activities. These were categorized under training to minimize the size and complexity of the survey instrument.] The topics covered ranged from healthy life style practices (e.g., diet and exercising) to special health conditions (e.g., diabetes and tuberculosis) to English as a Second Language. Evaluation of trainings was minimal. The typical practice was to administer a brief test after each training on the topic covered. In several cases, client satisfaction surveys were conducted as a form of evaluation.

Domain 4: Increase Consumer Knowledge of Preventive Health

Trainings/Education

The FY 1993-94 OMH grants had substantial impact with respect to increases in consumer knowledge of preventive health. First, all 32 projects responding to the survey conducted 35 types of training[5] targeting LEP consumer populations[6] with health education/disease prevention information for LEP consumers. The 35 training types amounted to approximately half of all the types of training conducted. The targeted LEP consumers included the following:

- LEP Asian adults from seven different ethnic/national subgroups
- Asian seniors with chronic illnesses and their caregivers
- Native American parents
- Adult Latino men who have sex with men
- Latino women at risk for HIV/AIDS
- Monolingual Spanish speakers in rural and urban (housing project) areas
- LEP parents of children identified as at risk for developmental delays
- Pregnant teens, and teen parents with their partners
- LEP individuals who smoke, and their families
- Southeast Asian adolescent and adult women

In general, some form of training was common to most projects: of the 32 projects in the sample, 31 conducted some form of training as part of their work. Importantly, 72 percent (23 *projects*) offered education and prevention trainings *for the LEP populations.*

> *"In part because of the education they received through the OMH grant, Laotian women are now coming in for services during the first trimester of pregnancy. Before the OMH grant, these women did not see the need for this."*
>
> *"Awareness increased. Now people talk freely after our program about the HIV threat. I've seen that now people go in for testing and use preventive behaviors. Each person who is educated has been helping others to learn about this too."*
>
> *"The adolescent health survey that we conducted in 1994 shows that over 50% of adolescents now use condoms. Now condoms are distributed more freely. Our teen pregnancy rates have dropped dramatically in the last three years. In 1992, 41% of all pregnancies were to mothers under 18. We just finished the survey for teen pregnancy last week, and the figure dropped to 17% for 1997."*

[5] Again, training is defined broadly meaning education or skill building sessions, lectures, workshops, and similar modalities.

[6] The total of 35 is larger than the total survey N of 32 because some projects conducted more than one type of training.

To meet varying needs and cultural backgrounds, a variety of training approaches were used, including:

Telephone discussions/education	Use of audiotapes
Demonstrations (e.g., of condom use)	Handouts and print materials
Interactive exercises	Didactic presentations
Informal social gatherings with discussion	Skits, songs, and games
Motivational exercises (storytelling, drawing, etc.) for youth	Group discussions/opportunities for examining personal risk behaviors

There was a range of services that also contributed to an increase in consumer knowledge about health, where, during the provision of the service, information was often discussed or presented to the client. Examples of such services include:

- informal peer HIV counseling;
- informal health promotion;
- individual health counseling sessions;
- case management;
- home visits; and
- interpretation.

See Domain 3 above for a description of the number of such services provided.

Materials Development

Twelve of the projects sampled (38%) had as one of their primary foci the development and dissemination of health promotion materials. Of the 32 projects surveyed, at least 21 projects reporting created materials for the LEP consumer populations. Together, these projects created at least 67 different materials, with the most common being pamphlets (21 types), radio spots/hotlines (19 types), and videos (13 types) (See **Table 2-13**). Nineteen additional types of materials may have also been accessed by the LEP population, though the data is not clear (See **Table 2-14**).

Note that the term "minimum" (or "at least") is used because not all projects responding to the survey reported the total number of materials that they developed.

Table 2-13
Materials for LEP Target Populations
(Phase I Grantee Sample)

Material Type	Number of Different Materials
Pamphlets	21
Radio spots/hotlines	19
Videos	13
Newspaper articles	5
Directory of health care and/or social service providers	4
Curriculum	2
Newsletters	2
Posters	1
TOTAL	67

Table 2-14
Materials for LEP Target Populations and Other Audiences (Dual Audience)
(Phase I Grantee Sample)

Material Type	Number of Different Materials
Pamphlets	4
Curriculum	3
Directory of health care and/or social service providers	3
Videos	3
Audio tape	2
Children's materials	1
Posters	1
Protocol for using health mentors in clinics	1
Resource directory	1
TOTAL	19

"Now the information is all in one handbook, everyone can look at it, it's all in one place for all API groups to look at once. We were trying to erase the idea that some people had that our organization only serves Filipino, we wanted to serve all API populations with this handbook and I would say we have been successful in that. We still have the handbook in print and we still give it out to organizations."

Further information was obtained from the 22 projects in the sample that completed the followup telephone survey. This survey included some questions on the LEP consumer populations and project activities resulting in an increase in consumer awareness. Besides the trainings and materials discussed thus far, 17 of these 22 provided outreach services to their target populations. Of these:

- 100% conducted health presentations at schools, community centers, etc.
- 82% conducted one-on-one outreach/education
- 82% referred clients to services as part of outreach; 71% followed up referred clients
- 71% passed out prevention literature and other materials (e.g., condoms)
- 65% of the outreach programs included some case management functions as part of their outreach (e.g., client advocacy, accompanying clients to appointments, arranging services)
- 82% documented their outreach in some manner (through logbooks or other means).

Limited numbers are available on how many LEP clients were served through outreach. Generally, these numbers are not duplicative of numbers reported under services provided, although there is some overlap (noted where known). Methods used to document outreach included log books and materials distribution counts. Often, however, these methods were used inconsistently, so the examples of outreach impact that follow should be viewed as illustrative, not exact:

- In 1993, one project served approximately 1,000 people at health fairs.
- In 1994 a project provided limited case management (a type of outreach) to 268 individuals, and distributed 940 health pamphlets.
- Project staff at one community association provided case management services to 31 children in 1993, and 30 families with infants in 1994— its other outreach activities were not documented.
- In 1994 staff from this project provided limited case management to 457 people.
- A Health Center provided case management to 376 people in 1993, and 486 people in 1994.
- Staff at one project distributed over 1,000 HIV/AIDS pamphlets in 1993.

Domain 5: Serving as a Catalyst to Develop or Change Existing Health Policies at the Community Level

AND

Domain 6: Influencing State/National Policies Targeting LEP Minority Populations

In addition to expanding the capacity of local organizations, the hope was that the one-year projects funded in 1993 and 1994 would serve as a catalyst for developing or changing existing policies related to providing health care to LEP populations. Community, State, and National level changes were envisioned. Grantees were asked if their projects had spurred changes in coalition development, legislative and/or regulatory changes, policy development, and developing LEP clients as resources within their communities. Overall, these projects had less success serving as catalysts for changing health care policies at the local level than they did in building the capacity of their own organizations or CBOs to address access to health services for LEP minority populations. They were not successful in changing policies at the State or National level, *however, we note that by nature, major impacts at the state or national level are an unlikely result of a small, one year grant.* Therefore, no results in Domain 6 were achieved, and this section will discuss only impacts from Domain 5.

Coalition Development

Five of the 32 grantees sampled reported that because of OMH grant activities, (local) groups were formed to address health services for the target population. The activities of such groups took a variety of forms. One project reported that alliances were formed to address training needs of interpreters and medical providers to better serve patients. As a result of OMH-funded grantee activities, a coalition of nonprofit health organizations carried out a study of Latino health in the Washington, D.C. area. AIDS Awareness Committees were formed as a result of another project's activities. These committees carry out AIDS prevention activities in the schools and community center. A community health clinic was built to serve low income families who are mostly Southeast Asian patients from the work done on the OMH project.

Policy Development and Regulatory Changes

Only one project reported that changes in local policy regarding access to health care by the LEP community resulted from project activities. The spokesperson for this 1993 OMH-funded project indicated that the project produced a policy to maintain ongoing funding to address the target population's health needs. None of the projects reported any city, county or state policy developments or guidelines regarding access to health care by the LEP community because of project activities.

Client Resources

Beyond increased organizational capacity, some grantees were able to train or otherwise develop LEP clients so that these clients could become resources within their local communities. Six of the grantees were successful in this arena. For example, interpreters trained by one project became resources for local medical and mental health providers. "Bridgers" trained by another project continue to volunteer as community health educators. They use the materials developed with OMH funds to speak at schools, churches and other groups in the community.

Project Evaluations

Although this is not a specific domain, we have added this section because it is important to describe, at least in brief form, how these one-year projects fared with respect to evaluation. However, while the evaluations are described, there is very little in terms of comparable methods that can be analyzed.

Evaluation Designs. Not surprisingly, 25 of 32 projects sampled had as the basis for their evaluation monitoring the achievement of their objectives (one additional project was unclear in their response but did conduct an evaluation). Six grantees did not answer the evaluation design question. Of those who did respond, at least one may not have completed its planned evaluation. *Twenty of the 26 also conducted additional evaluation activities, which is surprisingly high for one-year grants.* These additional evaluation activities included the following:

- Post-test interviews with LEP clients to measure general effectiveness of the project in preventing illness/promoting health care -- measuring dimensions of personal responsibility, utilization, and attitudes. The same project also conducted a client satisfaction interview with 42 project participants, and a somewhat informal assessment of outreach activities.
- Followup interviews and tests with physicians who were program participants to test knowledge; followup to assess performance on board exams and residencies; and followup to assess how many of these physicians are serving the LEP target population. Outreach activities were tracked using a logbook.
- LEP client rating of educational materials.
- Participant evaluation of cultural awareness workshops; pre/post tests of knowledge gained. Also, participant rating of pilot training curriculum.
- Provider assessment of health information pamphlet.
- Qualitative assessments of trainee performance.
- Use of outside evaluators to assess process/accountability and analyze impact through participant surveys/interviews.
- Use of an Advisory Council for project feedback; curriculum needs assessment, pilot test, and pre-post knowledge assessment.
- Participant satisfaction surveys; evaluation questionnaires.
- Measuring the number of home health workers who received state certification.
- Pre-post skills test for interpreter training.
- Client assessment of health care access needs against satisfaction with program services.
- Self-report behavior change surveys or questions.
- In-depth interviews with health providers and administrators on their perceptions of (provider) training.
- Pre-post knowledge and behavior assessments, or post-only.
- Staff debriefings.

- Extensive process monitoring with field notes, informal interviews, and participation in staff activities.
- Use of community intervention and/or outreach forms that describe implementation process.
- Pre-post assessment of number of complaints about access to health care by LEP population.
- Provider satisfaction survey (providers who used community health workers from grantee).
- Tracking of participation (process).

Evaluation Outcomes and Findings. Evaluation outcomes included the meeting of goals and objectives, and a range of questions about numbers served, effectiveness of project components, accessibility and attractiveness of the project, amount of information learned, increase in awareness, and, generally, the kinds of findings to be obtained from the designs listed above. Specific results are discussed in Domains 2 and 3.

Additional evaluation findings showed, for the most part, considerable gains made by project activities, primarily in short-term changes in awareness or skill levels. Additional evaluation activities varied by project, and, since there was little or no comparability, can be reported only anecdotally. Some highlights:

- Ninety-eight percent of the 38 Asian-American CBOs who reviewed an HIV/AIDS booklet prepared by one OMH project reported that the booklet increased their knowledge.
- Most of the participants in one 1993 project reported knowing more about health and disease from participation in the project; more than 50 percent said they were able to manage their illnesses better; and the majority felt more confident about their ability to access care. In the 1994 project carried out by this group, results were similar, with increases in self-reported health care utilization as well. However, pre-and post tests of health lectures (one of several program modalities) showed that the cholesterol lecture was the only one that apparently resulted in an increase in knowledge.
- Following an interpreter training conducted as a part of a 1994 project, 20 of 28 trainees scored 90 percent or better on the post-test (of interpreter skills/knowledge).
- In one evaluation assessment, a needs assessment was conducted in which it was found, among other things, that: 86 percent of Laotian respondents said that there is never anyone at their medical facility that can communicate effectively with them; 69 percent of Hispanic respondents reported having difficulty being understood; while, satisfaction with medical care was relatively high for both Laotians and Hispanics (76% and 83%).
- Out of 23 persons who attended two smoking cessation classes conducted by a 1994 project, 13 reported that they had stopped smoking by the end of the class (each class was 3-6 sessions).
- A 1993 project reported an interesting finding from its post-test of health professionals in a cultural awareness workshop: a significant decrease in these professionals' ability to make clinical judgements in working with Hispanic/Latino patients. This was attributed to an increased awareness about the need to consider cultural background (perhaps, then, also increasing their uncertainty about the judgements they do make).

- An agency with a 1994 project reported a 50 percent self-reported increase in safe sex practices, and gains of 70-80 percent in knowledge about HIV/AIDS among target population members who participated in the project. [NOTE: these data are distorted because pre and post-test respondents were from the same household, but were not necessarily the same people.]
- One community center project found that home visits, informal discussions, and such events as health education karaoke parties are most effective with Southeast Asian women, even if not viewed as "cost-effective" in the short term. In addition, health education in general was most effective if connected with interpretation and services.
- In a survey of providers who used services provided by a health center's OMH-funded services (1993), 38 percent said translation/interpretation was most important, followed by home visits and client followup (24% each).
- An important finding from one of the 1994 projects was that it is often difficult to convince professional health providers that community-based and lay worker education/outreach programs are important, even when the providers use program services. [This is an issue faced by many community health projects.]
- For one center, cultural competency training was effective in the short term. Sixty-three people attended these sessions; the average pretest competency score was 57 percent, while the post-training competency average was 85 percent, an average gain of 27 percent. The on-site Spanish classes were, however, much less successful, due to attendance problems.
- One project's presentations to health professionals on issues of Hispanic culture and health were effective in raising knowledge levels, typically by gains of five to 40 percent (depending upon the question).
- A 1993 training for health care workers demonstrated some effectiveness in increasing knowledge about Hispanic/Latino culture, improving providers' ability to deliver health care services to this population. There were two groups of trainees. In the first group, 93 percent of training participants achieved a competency score of at least 80 percent on a post-test measuring their understanding of Hispanic/Latino culture, and 88 percent achieved a score of at least 80 percent on their skills in providing services to this community (ability to make clinical judgements). However, the second training cohort did not show such gains, and it is unclear at this time what the reasons are for this difference by group.
- Staff at a Native American project learned that focus groups, particularly if conducted at the community level as opposed to at a central location, were an effective method for teaching about HIV/AIDS, based on pre and post test results. However, this was more true for men than women—men seem not to participate readily in focus groups, believing that it is not appropriate to talk about sex in a mixed group.
- Fourteen out of 15 families working closely with bicultural mentors, providers noted that there had been an improvement in these families' abilities to work with the provider on health care needs.

Problems in Conducting Evaluations. Although most FY 93-94 projects did conduct some evaluation, this remains a difficult and problematic aspect of the grants made during these years:

- Evaluation was not always completed as planned; many initial designs were perhaps too ambitious.
- There was little or no comparability in evaluation methods that would allow evaluation across sites.
- Pre- and post-test measures of knowledge gained from particular health education/training sessions, a common method, does not reveal much with respect to changes made in actual health behavior.

CHAPTER III

Phase II Results: Site Visits to FY 1995 (Current) Grantees

Data collected in the Phase II site visits included both quantitative and qualitative data from a sample of 9 out of the 15 total FY 1995 grantees. In particular, a substantial amount of qualitative data was collected through interviews and focus groups. In order to minimize the burden on site staff, particularly the project director, an abbreviated set of quantitative data was collected, using a subset of questions taken from the Mail Verification Survey so that some standardized data would be collected across both Phase I and II.

It is important to note that the Phase II projects were ongoing at the time of the site visits, and were not scheduled for completion until September at the earliest. Therefore, data collected from these projects is not final data, but a reflection of implementation and impact at the time of this study.

DESCRIPTION OF PHASE II GRANTEES

Funding and Project Locations

Phase II projects were funded in FY 1995 for three years, with annual budgets ranging from $69,000 to $100,000.The average award was about $100,000. Four projects provided in-kind matches, ranging from $4,000 to $100,000. Additionally, two projects listed funding from other organizations in the amount of $10,000 and $620. Eight of the nine projects (89%) engaged in partnerships which in total involved more than 35 agencies. Projects reported multiple types of arrangements with their partners or collaborating organizations. These included seven formal memoranda of understanding, seven collaborative agreements, three memoranda of agreement, and two subcontracts (subcontracts were $3,000 and $50,000). The types of partnership agencies varied widely; most often they were hospitals, clinics and primary care centers, social service agencies, and community-based organizations. The purpose of the partnerships was most often for referral, primary care services, or to provide education and training to staff.

Of the nine Phase II grantees site-visited, four were located in California, two in New York, and one each in Illinois, Washington, D.C., and Kansas. Seven of the nine projects served urban locations, one was in a suburban location, and one was rural. More than two-fifths (43%) of the project activities were implemented city-wide or city/county-wide, another 43% served multiple cities or counties, and one operated at the neighborhood level. The sample selected provided services to diverse geographic locales, which were representative of the areas served by all 15 projects.

Grantee Types

Seven of the nine grantees were nonprofit organizations; two were county health departments. The nonprofit organizations were made up of four community mental health centers, one hospital, one social service agency, and one community advocacy organization.

Project Focus and Major Activities

Projects planned to focus on nearly 20 primary health issues from the National Health Goals for the Year 2000. Most frequently, these were STDs, family planning, HIV, cancer, TB, heart disease and stroke, diabetes and chronic disabling conditions, and nutrition.

The majority of the projects undertook activities in several areas: six projects (67%) provided training or education, six (67%) provided services that increased access to direct medical care for the LEP population, three disseminated materials, and two (22%) focused on other activities, such as, interpreting or providing translation services for clients, or providing increased access to services (numbers exceed 100% because projects selected up to two primary focus areas).

TARGET POPULATION

Income and Employment Levels and Language Ability

Eight of the nine projects (89%) served low income level target populations; the ninth reported serving mixed income levels. The average unemployment level among the target populations across the six projects that responded to this question was 55%; unemployment ranged from 5% to 92%. The limited-English speaking ability of the project's target populations ranged from 55% to 90%, with the average population served being 82% LEP.

Target Population Compared with Community in Which Projects Were Located

In general, the target population tended to be similar or more disadvantaged than the respective community as a whole. For example, six of the seven projects responding (86%) reported that the income level of the general population was low; the seventh reported a middle income level. Compared with the general population, six projects are equal to the target population and one project had a target population whose income was lower than that of the general population.

The average unemployment level in the four communities responding was 31%, and ranged from 4% to 60%. When compared to the target population, two projects had unemployment rates lower than the general population and two had unemployment rates equal to that of the general population.

Two of the five projects responding reported that more than half their community had limited or no English speaking ability. The limited or non English-speaking ability of the general population averaged 49%, and ranged from 13% to 90% among the five projects responding to this question. When comparing the percentage of the target population's English speaking ability to that of the general population, three projects had higher percentages of LEPs than the general population (e.g., in three projects, the target population had a lower percentage of fluent English-speaking ability than the general population).

Ethnic Groups Served and Languages Spoken

Five of the projects served Asian groups, 4 served Hispanics/Latinos, and one project served Africans (see **Table 3-1**). There were 11 specific ethnic groups served among the Asians, most frequently Cambodian/Khmer, Chinese, Laotian, Vietnamese and Korean. Among Hispanic/Latino populations, Central Americans, Cubans, Mexicans, Guatemalans, Hondurans, Nicaraguans, and Salvadorans were most frequently served. African groups were served at only one site, and clients were primarily from West Africa, although other regions of Africa were represented as well.

Table 3-1
Target Population's Ethnic Background, (Phase II Grantee Sample)

Ethnicity of Target Population	No. of Projects Serving this Population	Percent of Projects serving this Population*
ASIAN POPULATIONS	**5**	**56%**
Cambodian/Khmer	5	56%
Chinese	5	56%
Laotian	5	56%
Vietnamese	5	56%
Korean	3	33%
Other Asian	2	22%
Thai	2	22%
Filipino	2	22%
Mien	1	11%
Japanese	1	11%
Hmong	1	11%
HISPANIC/LATINO POPULATIONS	**4**	**44%**
Central American	4	44%
Guatemalan	4	44%
Honduran	4	44%
Nicaraguan	4	44%
Salvadoran	4	44%
Cuban	4	44%
Mexican	4	44%
Puerto Rican	4	44%
South American	3	33%
Other Central American	3	33%
Dominican	3	33%
AFRICAN POPULATIONS including Ethiopian, North, Central, & West African	**1**	**11%**

*Projects served multiple ethnic populations, therefore column totals exceed 100%.

More than 18 languages were spoken by the target populations served (see **Table 3-2: Language Spoken by Target Population**). Most frequently these were Lao, Vietnamese, Khmer, and Spanish, followed by Chinese, Tagalog, French (for populations from Francophone West Africa), Korean, and Ilocano.

Table 3-2
Language Spoken by Target Population
(Phase II Grantee Sample)

Languages Spoken by Target Population	No. of Projects Serving this Population	Percent of Projects Serving this Population*
Khmer (Cambodia)	4	44%
Lao	4	44%
Spanish	4	44%
Vietnamese	4	44%
Chinese	3	33%
Tagalog (Phillippines)	2	22%
French	2	22%
Korean	2	22%
Ilocano (Phillippines)	2	22%
Amharic (Ethiopia)	1	11%
Visayan (Phillippines)	1	11%
Wolof (West Africa)	1	11%
Soninke (West Africa)	1	11%
Mandingo (West Africa)	1	11%
Thai	1	11%
Tigrinya (Eritrea, Ethiopia)	1	11%
Fula (West Africa)	1	11%
Hmong (Laos)	1	11%

*Projects served multiple ethnic languages, therefore column totals exceed 100%.

Age and Special Characteristics

Two-thirds of the grantees served target populations of all ages (adults and children) and three projects (33%) served adults or seniors only. Five of the projects noted special characteristics for the target populations served; most frequently these were transgendered individuals, gay men, restaurant workers, women who work in massage parlors, undocumented Latinos, and low income women with no health insurance.

Project Staffing and Staff Retention

Out of the nine projects, 4 reported that the project activities were new to the organizations and five reported that they were an expansion of existing activities. Four projects also co-located their services with another agency. An average of 2.0 FTE (full-time equivalent) positions were filled using OMH funding; and an average of 2.5 staff members were used to fill these positions. Five of the nine projects used consultants to provide project services as well. Six of the nine projects (67%) reported using a mixture of existing and new staff to provide OMH-funded activities. All projects used staff who reflected the ethnic makeup of the target LEP participants and who spoke the primary language of the LEP clients.

All but one project reported that their staff needed additional training to carry out project activities. Most often, this training was related to the project content, for example, HIV/AIDS, STDs, confidentiality, cultural sensitivity, CPR, medical knowledge/interpretation, prenatal care, evaluation, and focus group training.

Seven of the nine projects surveyed reported turnover among OMH-funded project staff. One project had one person leave during the grant period, one project had two leave, two projects had three leave, and one had five leave. The most frequent reasons for staff turnover were that staff found better career opportunities or better pay, staff returned to school, staff position was eliminated due to reorganization, or staff relocated or retired. Again, as noted in Chapter 2, staff retention is clearly an issue that needs to be addressed.

Just one-third of the projects felt that burnout was an issue for OMH-funded staff. For those three projects that reported it was an issue, the most frequent cause of the burnout was due to the increasing number of clients, limited resources yet increasing responsibility and increased stress for staff, and lack of coordination.

Eight of the nine projects used volunteers to carry out OMH-supported activities. Three projects used five or fewer volunteers, while two projects used more than fifty volunteers to conduct health lectures, outreach, and health screenings.

PROJECT NEEDS ASSESSMENT

Six of the nine projects conducted needs assessments specifically as part of their grant activities (again, not including use of existing needs data for purposes of their grant application). Of those that did, four conducted assessments after the grant was awarded and two conducted assessments both before and after. Key needs assessment findings revealed that medical terminology, knowledge of cultural belief systems, locating qualified physicians, language barriers, and transportation were the main barriers. Focus groups conducted by a county department of community health found that the awareness of interpretive services differed by ethnic group; the Hispanic groups had good awareness of the interpretive services but the Vietnamese did not. Both groups preferred the interpreter to be mature but the most important trait was for the client to be treated with kindness and "not talked down to." *Because (in the focus groups) only one out of 13 Spanish clients and one in eight Vietnamese were literate in their native language, both groups also felt videos in their native language would be preferred to written materials.* This is an issue that needs further assessment, especially since so many projects produced print and written materials.

A California health clinic conducted several needs assessment surveys of all its own support staff as well as with a County Department of Education and clinic sites in two neighboring counties, as well as key informant interviews. Key findings from these assessments include:

- 36% of the respondents from the clinic and 89% of the respondents in the other sites were interested in acquiring or improving their accuracy when interpreting
- up to 83% would like to receive non-linguistic cultural training in preventive health
- Health care staff need to:
  - be more aware of the repercussions of mistranslation
  - learn to remain professional with foreign speakers
  - understand different cultural beliefs
  - understand the relationship between beliefs and good health
  - become aware of their language limitations
  - treat the whole person, not just the body.

Five of the six projects that conducted needs assessments followed up on gaps or problems identified in their needs assessment by providing transportation, translation, and interpretation services; teaching cultural sensitivity and tutoring; providing access to HIV/STD/TB prevention, screening, and treatment; providing medical terminology training; and training medical providers in cultural awareness and using interpreters.

Projects identified a total of a dozen barriers facing their target populations with respect to accessing health services for the health problems of primary concern to their projects, most frequently, language/lack of translation materials and lack of language-appropriate information, signs, or brochures—9 projects (100%), gap between target population's health practices and mainstream health practices—8 projects (89%), lack of culturally appropriate health education materials—7 projects (78%), lack of health insurance or other benefits to cover costs—7 projects (78%), lack of appropriate training materials for providers—7 projects (78%), lack of money—7 (78%), lack of

awareness among providers—6 (67%), lack of awareness among target population—6 projects (67%), and lack of transportation or geographic access—6 projects (67%) (see **Table 3-3**).

Table 3-3
Major Barriers Facing the Target Population's Access to Health Care
(Phase II Grantee Sample)

Major Barriers facing Target Population	Number of Projects reporting these Barriers	Percent of Projects reporting these Barriers*
Language/lack of translation materials, information, signs, brochures	9	100%
Gap between target population, health practices, and mainstream health practices	8	89%
Lack of culturally appropriate health education materials	7	78%
Lack of health insurance or other benefits to cover costs	7	78%
Lack of appropriate training materials for providers	7	78%
Lack of money to access services, transportation, etc.	7	78%
Lack of awareness among providers (about bilingual/bicultural issues)	6	67%
Lack of awareness among target population	6	67%
Transportation/geographic access	6	67%
Education level of LEP members	5	56%
Lack of available services	3	33%
Social stigma, cultural belief about diseases, and perceived risk, stigma of occupation, stigma of drug use	1	11%

*Projects reported multiple barriers in accessing health care, therefore column totals exceed 100%.

GOALS AND OBJECTIVES

Projects identified an average of two goals and eight objectives each, for a total of 17 goals and 75 objectives. The types of objectives included:

- education and training—45%
- outreach—11%
- needs assessment—4%
- process objectives—9%
- materials development and/or dissemination—12%
- capacity building—7%
- access to health/medical services—16%
- community impact/policy change—1%

The vast majority of objectives remained the same throughout the project—19 objectives (25%) were revised or created later.

Fifty-six percent of the projects fully achieved more than 40% of their objectives; another 56% partially achieved more than half of their objectives.

While achievement of objectives was assessed, it is acknowledged that the Phase II projects were ongoing at the time of data collection; therefore, these data are provisional pending the completion of these projects. Out of all objectives, 28 (37%) have been fully achieved; 28 (37%) have been partially achieved, 3 (4%) have not been achieved, and 17 objectives (21%) have not yet been measured. Exhibit 3-1 shows that there were no significant differences in the achievement level *by type of objective* as there was in Phase I; while materials development objectives were more often fully achieved by Phase I projects, there was no difference among Phase II projects. This conclusion, again, is provisional, but a significant number of project objectives have been achieved *although the projects are not completed*, suggesting that when completed, achievement levels will be higher.

Table 3-4
Achievement Level by Type of Objective
(Phase II Grantee Sample)

Type of Objective	Number of Objectives	Achievement Level Determined at Time of Assessment		
		Fully Achieved	*Partially Achieved*	*Not Achieved*
Education & training	20	9 (45%)	11 (55%)	0
Materials develop/dissemination	8	4 (50%)	4 (50%)	0
Service delivery	11	6 (55%)	5 (45%)	0
Capacity building	5	3 (60%)	2 (40%)	0
Needs assessment	3	0	3 (100%)	0
Outreach	7	5 (71%)	2 (29%)	0
Process objectives	7	2 (29%)	2 (29%)	3 (43%)
Community impact/other	4	1 (25%)	3 (75%)	0

Note: Sixteen objectives were excluded because their achievement level to date is unknown

BEFORE THE OMH GRANTS WENT INTO ACTION: COMMON NEEDS FACED BY THE TARGET COMMUNITIES

In the interviews and focus groups conducted on site (by the site visit teams), a number of commonalities were reported in terms of the needs faced by the projects prior to commencement of their FY 1995 OMH grants.

Projects focusing on interpretation issues noted the following needs:

- ***Burgeoning populations of LEP minorities, with limited capability within the local health/social service provider system to handle the situation.*** Very few hospitals/providers in the grantee service areas had sufficient interpreter services to handle the caseload. [For example, one children's clinic open in the evening noted that 40 or more monolingual Spanish speaking clients might come in on an typical evening, yet they often have no one available to interpret -- and must rely solely on several bilingual staff.] Some providers had access to networks of on-call interpreters, but these were typically untrained in medical terminology, and not always available. Or, where there was some on-staff capability, the interpretation services were not available at night/24 hours, creating a problem with respect to off-hour emergencies. A typical practice for providers, when the need for interpretation came up, was to *pull almost any available employee* (even, for example, from the hospital cafeteria) who was a speaker of the necessary language. Once again, however, these individuals were not trained in medical (or any) interpretation. Finally, providers would often ask the LEP patients to bring their own interpreters -- most commonly a family member. In this situation, not only is lack of training a factor, but inappropriate matches occurred -- e.g., where a child ends up as interpreter for an adult ("How," asked one grantee staff, "is an 8 year old going to know the terminology for family planning?").

- ***Problems of wasted time, delays in care, and confidentiality.*** Providers, when they used their own staff (not staff who were interpreters) to interpret, found considerable problems of inefficiency and wasted time -- the time necessary to fill in for the staff member while he/she was diverted for interpreting, or the substantial time wasted in trying to serve an LEP patient without interpretation. In addition, enormous problems of confidentiality result if untrained staff or family members are interpreting. Consider, for example, using such informal interpretation in the case of an STD situation where very sensitive information must be exchanged in the doctor-client interaction. Finally, if a patient does not understand what he/she must do regarding a particular treatment protocol, valuable time and duplication of effort may be lost -- a prime example is where an LEP patient does not understand that before surgery, no food or drink (other than water) may be taken for a specified period of time. If the patient comes to a scheduled surgery without having followed this regimen, the surgery must be canceled and rescheduled.

- ***The danger of misdiagnosis, and miscommunication regarding treatment.*** If patients cannot effectively communicate their symptoms, the danger of misdiagnosis is high. Moreover, treatment compliance is seriously affected; if medication is prescribed, for example, and the patient does not understand proper dosage, serious consequences can result: In one reported incident, a monolingual Hispanic woman had a 10 year old cousin who went to the emergency room with a throat problem. She was given Tylenol. Her parents kept giving her more and more

Tylenol, not understanding the dosage instructions. The girl then died of liver failure due to overdose of Tylenol.

For grantees who provided target population education/outreach, materials development and client advocacy, other needs existed:

- ***Lack of awareness among the LEP population with respect to diseases and available services/treatment.*** Among one Cambodian community, for example (particularly among older Cambodians), awareness about cancer, its causes, and prevention was very low. Conducting breast self-exams was a difficult concept for Cambodian women, and many men had been smokers since they were young boys in the Cambodian countryside, where boys smoke both because it has "cachet," and because it keeps the mosquitos away -- important if one is taking care of cows, water buffalo or other animals.

- ***Unfamiliarity with the health care system, and culture-specific knowledge about health.*** In particular, many LEP populations are unfamiliar with the general concept of prevention, including both lifestyle factors and preventive medical care (e.g., pap smears). It is most common to go to a doctor when the symptoms are already present, which, in the case of cancer, may be too late. Moreover, treatment from home-country doctors may consist of pain reduction or symptom reduction, as in the case of many Chinese/Southeast Asian herbal remedies for cancer, and these doctors may themselves be unfamiliar with the network of specialists available. LEP populations are also generally unfamiliar with the complex process of obtaining health care coverage in the United States, from paperwork, to billing, to multiple appointments in, perhaps, different clinics. Added to this is the process of obtaining appropriate health insurance coverage, again requiring the filling out of forms. Finally, many LEP patients are accustomed to a traditional role for doctors as authorities, and are thus not used to "talking back" or asking questions to doctors.

- ***Fear and mistrust based on experiences in the home country, during migration, and in the United States.*** This was a key factor, particularly for Southeast Asian and Central American LEP populations. With respect to Southeast Asian populations, many are coming from an experience of repression, war, and nightmarish escape histories. So, before being able to understand the particulars of the health care system, it is first necessary to establish a basic sense of trust; during one site visit in the San Francisco area, Cambodian seniors already living in "deplorable" conditions were afraid that the site visit team was there to take away what already few public benefits they received. Central American migrants commonly report a fear that if they use the health care system, their "papers will be taken," or they will be "found out" by the INS. They are also concerned that if they use public health services, they will lose their jobs, or not be able to become citizens. Generally, there is a fear of authorities, or "fear of uniforms."

- ***Lack of relevant health education materials.*** While there are some health education materials available in Spanish and other languages, target LEP populations for the FY 1995 grantees encountered limited materials availability. For one, many target population members were, in fact, non-literate in their own languages, so that even if written materials were available, the materials would be of little use since they were designed for literate persons. Second, some projects worked with populations speaking a broad range of languages for which few, if any,

materials were available. For one project, these languages included Fulani, Wolof, Mandingo, Amharic, Bambara, and others. Third, there was a great unfulfilled need not only for health education materials, but for more basic items in languages other than English, such as medical intake forms, billing or public assistance forms, and the like.

- ***Insensitivity of health care professionals.*** One of the most common complaints by LEP population members was that American doctors tend to be brusque, impersonal and/or unaware of a number of interpersonal cultural issues. For example, Hispanic/Latino clients, particularly women, are very uncomfortable when a doctor spends no time even asking about her family, or how they are doing, or other rapport-building interactions. LEP patients even reported subtle gestures, such as when doctors made eye contact only with the interpreter, and not them. Southeast Asian women, and Hispanic/Latino women, are also typically uncomfortable disrobing -- even for an exam such as a mammogram. In addition, some doctors ignore or are unaware of traditional health remedies that their patients may be taking/doing in parallel. Hispanic/Latino patients, for example, have in their home countries a wide access to drugs and other medicines that would be available in the U.S. by prescription only. If doctors do not ask about this, they may prescribe a medicine for the patient that conflicts with something they are already taking. There were other situations as well: one Hispanic transgendered individual, for example, reported that health professionals refused to call him by his (preferred) female name. Moreover, *insensitivity was not just attributed just to American doctors.* A number of complaints were voiced by Southeast Asian women concerning doctors from their own countries who tended to ignore or invalidate reports of symptoms made by women as simply a product of irrationality or emotionalism, or even as a threat to their authority. Recently-immigrated Hispanic clients sometimes experienced resentment from other Hispanic health professionals who were long-time U.S. residents (and who spoke English), or even on some occasions because of class or national origins.

> *"Sometimes health care providers are simply unaware or insensitive to what they put patients through. In one example, a 70-year old Hispanic woman had pains in her head around 11 pm. She went to the emergency room, and was told that because 'she had no papers' she would have to wait until the head nurse came in at 8 am. She ended up staying two nights in the emergency waiting room."*

There were also several general issues faced by grantees as part of the setting within which they had to operate:

- ***Poverty, non-literacy and immigration issues among the target LEP population***. Many of the target populations for the OMH grants were refugees and/or migrants, who came from rural areas and situations of civil war, or from situations of serious poverty -- and who also are non-literate in their own language, do not have transportation, and are mistrustful of authorities. This is particularly true with respect to undocumented immigrants.

- ***Increasing presence of managed care in the public health domain.*** More and more public health or Medicaid services are being provided through managed care arrangements. With respect to LEP populations, this becomes very important because the managed care contracts are governed by *performance standards, or standards of care.* In order for these populations to be well-served, the performance standards need to include language and cultural competency elements. It also puts pressure on existing community-based health providers, or other public health providers, to compete with the managed care organizations that are coming in to "bid for their customers."

- ***Bureaucratic rivalries/"turf" issues.*** Site visit grantees that were based in public health agencies faced issues unique to that setting. For one, there tended to be departmental rivalries -- sometimes along ethnic lines -- that served as impediments to program implementation. When a new program is instituted in one department, individuals in other departments who may have been involved in (even limited) provision of those services feel threatened, and factions form, potentially undermining the effectiveness of the "new" activities. Thus if OMH funds interpretation services, and there is already some limited interpretation being performed (albeit without training or structure) by others in the same organization, these individuals may not be cooperative with respect to the new services. It was also clear that *implementation in such cases is greatly aided by the enlistment or cooperation of at least one high-level individual -- where this occurred, many implementation barriers were overcome; where it did not, they remained.*

- ***The politics of ethnicity in the community.*** Unfortunately, the competition for grants and services, especially in the current environment of limited public dollars, produces competition and rivalries by ethnic group. The resulting politics can impede program functioning in the bureaucratic setting for agencies serving diverse, racial/ethnic constituencies. Thus if one group appears to be getting funds, others may develop resentments that the needs they face are either not understood, are being ignored, or that they are not "in favor" at the moment.

- ***Union issues.*** Though the site visit staff encountered this issue in only one site, it is likely to be a factor in other sites as well, where a grantee is a large public health agency. The issue centered on how to treat staff whose capabilities increased due to participation in a language and cultural awareness course. Should the position be classified differently? Was the agency authorized to use them or place them at any clinic it wanted (where the perceived need was) due to their new skills? How was this to be regulated? Ultimately, these kinds of questions were resolved when the union was brought into the process of developing a certification process for bilingual staff.

FINDINGS BY DOMAIN

Domain 1: Building the Capacity of CBOs to Address Access to Health Services for LEP Minority Populations

Building CBO capacity involved a number of factors. In terms of funding, three of the eight grantees reported that they were able to generate additional funds to supplement OMH support in carrying out their project's activities. Two projects secured money from two sources. The amounts of additional funding tended to be relatively small, ranging from $3,000 to $10,000.

But the more common patterns with respect to capacity-building were related to: the experience of being a provider of a unique service in the community; or the growth of staff capabilities. The following examples illustrate this impact:

- Among the network of community clinics in Washington, DC, only the OMH grantee offers interpretation services (because of OMH funding), and the demand for these services rose dramatically from a rate of about 6 interpretation requests per week to about 20-30 per week. Because the grantee has become known for this service, they have been asked to make presentations at other organizations, such as the Catholic Center. They have also been considering a transition, at some point, to offering these services for a fee.

- Because of its capabilities gained through the interpretation service, this grantee has also been able to win new grants. They recently won a county grant to conduct HIV/AIDS outreach/education in the Hispanic gay community -- a grant that "they couldn't have won two years ago."

- Because of its interpretation and translation service, one grantee increased its recognition-level in New York City as a key link to the West African community, and as a result has been asked to participate in very important efforts to address the spread of HIV-2, an HIV strain with a high prevalence in West Africa. The interpretation staff itself has also become well known in the community, to the point that West Africans often come to know the project, and gain entry to the health care system, through one of the health educators, such that the project becomes known as "Abebe's (health educator) program."

- Similarly, a California grantee serving an API population has a cadre of health educators working in four languages. These health educators have become known (or become more well-known) in their respective communities as key points of contact when help is needed -- with respect to health and other issues (e.g., social services). *It is, in fact, common for interpreters and health educators in the OMH projects to become "community advocates."*

- At one grantee organization, a health department, the OMH Project Director has become known as a leading community advocate for health and related issues. She has, in fact, built this reputation with the help of two OMH grants -- an earlier grant to develop a community coalition, and the current grant. The coalition has 500 members now, and was a key factor in the success of the current grant, because it served as a ready-made network for recruiting participants into the language/cultural awareness training, and for promoting the general issue of culturally-appropriate health services. Moreover, the Project Coordinator, who started there as an assistant while a Public Health graduate student, has gained considerable experience and exposure as well through her participation on the project, as have other staff.

- The Project Coordinator at another grantee has increased her profile as a community activist through her efforts to promote the interpretation service. Because of these efforts, she and the program have gained some media exposure, and she has been asked to make presentations and participate in discussions about Hispanic health issues with the city government, and with a coalition called Hispanic Vision. Requests for interpretation services have tripled since the project began.

- Because of her OMH-funded efforts (covering three counties) to increase and improve the capability of health providers to utilize interpreters, the Project Coordinator for a grantee in California has been asked to participate on numerous panels and on a statewide (e.g., the California Wellness Foundation) panel concerning language and standards of health care.

Domain 2: Did the Program Build Capacity of Health Care Professionals to Address Cultural and Linguistic Barriers to Effective Health Care Service Delivery?

The answer to this question is a solid "yes." Eight out of the nine projects site-visited included some provider training. This usually took the form of language/cultural awareness trainings, or trainings on how to work with interpreters. In addition, five of the nine projects provided interpretation services, which in itself is a valuable support for health professionals working with LEP populations. Eight out of the nine projects also developed materials that could help providers, including curricula, and medical interpreters phrase booklets (See **Table 3-5: Materials Created for Health Care Workers**).

Table 3-5
Materials Created for Health Care Workers
(Phase II Grantee Sample)

Material Type	Number of Different Materials
medical interpreters phrase book	4
curriculum	2
other	1

Training for Health Care Workers

All nine of the projects conducted training programs as part of their grant activity (as noted in Chapter II, "training" is a broad category that includes a range of educational modalities). The nine projects conducted a total of 31 types of training. Of these training programs; 48% were designed for health care workers; 36% for LEP population, and 16% for current and candidate interpreters. Eight of the nine projects provided trainings for health care workers regarding how to more effectively serve the target population. (Several projects conducted more than one type of training addressed to several types of health care workers.)

Through these 31 training programs, the nine projects trained at least 2,325 health care workers and interpreters. *We know, however, that the exact number trained is significantly higher than this, for several reasons. First, for nearly half the trainings, the number in attendance was not reported. Second, training modalities such as health fairs seldom reported the number in attendance. Third, for training that was offered on video, there is no way of knowing the number of people who viewed the videos or how often they were shown.*

As **Table 3-6** shows, the 32 trainings served many different types of health care providers. The most commonly trained professionals included doctors, nurses, nurse practitioners, physicians's assistants, and community health workers. Other health care workers that were trained included health educators, outreach workers, interpreters, midwives, case managers, emergency room staff, and many other types of health care workers.

Table 3-6
Target Audience of Training
(Phase II Grantee Sample)

Target Audience of Training	Number* of Trainings Provided for this Target Audience	Percentage of Trainings Provided for this Target Audience**
nurse/nurse practitioners	11	35%
physicians	11	35%
physician's assistants	11	35%
community health workers	10	32%
LEP target population	10	32%
case managers	6	19%
health educators	6	19%
emergency room staff	5	16%
interpreters	5	16%
outreach workers	5	16%

* Out of the 31 types of training
**Projects provided training for multiple audiences, therefore column totals exceed 100%.

Seven of the nine projects reported using trainers whose ethnicity reflected the ethnic makeup of the LEP target population. Many projects undertook multiple types of training, two projects performed five types, two performed six types, and six projects offered three or four different types of training.

The training formats were most often a one-time workshop (43%), classes (13%), health fair (13%), education (10%), conference (7%), or technical assistance (3%).

Implementation Issues/Health Professionals

It is important to note that a number of grantees experienced similar implementation issues when working with health professionals. These included:

- ***Resistance to participation.*** Grantees that implemented language/cultural training for health professionals and public health staff found that these individuals often questioned their own need for training. Where language (Spanish) training was included, grantees also encountered attitudes such as "Why should we have to learn this? Why can't they learn English?" There was also some resistance based on a concern about learning new language skills as an adult.

- ***Lack of awareness or appreciation.*** For grantees providing interpretation, it was not uncommon for health professionals to treat the interpreters, or the interpretation service, as "non-professional." Doctors, for example, would call at the last minute for interpreters, ignoring the logistics that might be necessary to get an interpreter to the facility in time. Or, doctors/health professionals would not always react well if the interpreter had a suggestion (regarding, for example, cultural appropriateness) for the doctor, or when the interpreter tried to explain something to a patient -- anything outside a strict interpretation function. *Yet at the same time, one of the important roles for interpreters in many cases was as a "cultural broker."*

  Some of this resistance, however, was overcome when doctors/health professionals discovered how much better and more efficient their operations became when interpreting was available, or when they themselves developed enough cultural/language knowledge to handle situations they had previously been unable to handle (see Impact sections below).

Capacity-Building for Health Professionals -- Qualitative Impacts

The following are further descriptions of how OMH grantee activities increased the capacity of health professionals to address LEP minority health care:

- ***Efficiency:*** Across the board, when OMH-funded interpreters have been present, the time necessary for a given patient appointment is reduced. The long waits to find someone who could interpret, and the time it takes to attempt communication without an interpreter, is eliminated (or substantially cut down). In addition, interpreters act as patient educators to a very substantial degree, because they are the ones who actually relay information to the patient about their condition, what treatment options are available, and how to follow treatment regimens. For this reason, patient appointment time is also reduced because the patients become more educated about their condition and are thus able to better participate in their own care. Efficiency has also increased when staff themselves became more language proficient or more knowledgeable about cultural issues. They were more able to handle situations themselves.

- ***Provider-patient relations:*** By almost all accounts, various OMH-funded project modalities have had a very beneficial impact on the immediate environment of care -- in particular, the presence of interpreters and/or same-culture advocates, and the training of health provider staff in language and cultural awareness with respect to their client LEP populations. At one grantee organization (a public health department), for example, employees who participated in the language and cultural training[7] overwhelmingly felt more capable of working with Hispanic clients. Even if their Spanish capabilities are not fluent, staff who learned some (clinic-related) Spanish said that their patients appreciated their attempts and participated by correcting them, facilitating provider-patient relationships, and in turn giving the LEP patients a certain amount of confidence in attempting to use what English they knew. Importantly, these staff also felt much more capable of handling emergency situations concerning LEP Hispanic clients, and more capable of eliciting sensitive information, for example, concerning drug use or domestic violence.

[7] Provided by a language and cultural institute sponsored by the government of Spain.

"I think I appreciate more my patients that don't speak very much English since I've been trying to learn Spanish -- and I'm educated."

"It's not only the speaking, it's the relationship situation. They (patients) have more trust in you. You show them that you are trying to speak (their language), no matter how well you're doing."

Before the OMH-funded Spanish and Vietnamese interpreters became available, a local public health department "did the best they could" with LEP patients. The interpreters provided them with an important asset: There was an outbreak of syphilis in the winter of 1997/98, primarily in the Hispanic community. Department intervention specialists strongly felt that the outbreak would not have been contained without the presence of interpreters. With them, they were able to go out into the community, track the exposure pattern, and get the individuals involved into treatment. "Without them (interpreters) we would have been lost...For us they mean everything."

In addition, a number of innovative curricula and materials were developed to build the capacity of health professionals and staff:

- In conjunction with a Spanish language and cultural institute, one grantee developed an outstanding Hispanic language and cultural awareness training program and curriculum. The program includes practical, clinic-relevant Spanish language instruction as well as instruction on elements of Hispanic culture. Health and social service providers are the target audience. It was developed, in part, as a result of an undercover investigation by the institute staff conducted as a way of learning firsthand what some of the day-to-day obstacles were.

- In Washington, DC, a grantee developed a one-page cultural background form to be used with LEP patients. When the patient sees a doctor or provider, the patient (or accompanying interpreter) gives the form to the doctor/provider as an introduction to the patient's particular individual cultural and social background, specifically: language and country of origin; difficult experiences with migration or war; social support network; disease background; and use of traditional remedies (information obtained by interview with each patient). This information is intended to increase the provider's awareness of factors that may affect treatment, and to help the provider be generally sensitive to patient background factors.

- A California grantee developed a well thought-out curriculum for health providers on the need for, and how to use, interpreters. A second component of this curriculum focused on cultural awareness, primarily with respect to Hispanic/Latino patients, including a segment on Spanish health/medical terms, including colloquial terms used in different Central and Latin American regions. In addition, this grantee developed a model newsletter focusing on issues of culture and health, as well as interpretation, that they send out to an extensive mailing list of health providers in three counties. This newsletter (and a monthly bulletin that is also sent out) not only help inform the provider network about the issues, but serve as a very effective marketing tool with respect to securing interest in the training. *In fact, this newsletter and the bulletins were not part of the original project activities, but were developed as a strategy to overcome lack of interest/resistance from health providers regarding the interpreter/cultural awareness training.*

Domain 3: Did the Program Increase Access to Health Care for LEP Minority Populations and their Knowledge of/Ability to Negotiate the Health Care System?

AND

Domain 4: Did the Program Increase Knowledge of Consumer Health?

Results in Domains 3 and 4 will be reviewed together due to the extensive overlap between the two areas.

Services That Increased Access to Health Care

The FY 1995 offered a wide range of modalities that increased access to direct health services for their LEP minority populations. The two most often offered were interpretation and case management, followed by health screening and a list of others, as shown in **Table 3-7** below.

Table 3-7
Access Services Provided by OMH Projects
(Phase II Grantee Sample)

Type of Services	Number of Projects Offering Access Services	Percentage of Projects Offering Access Services*
case management	4	50%
interpretation	4	50%
health screening	2	25%
benefits counseling	1	13%
HIV testing and/or counseling	1	13%
home visits	1	13%
individual counseling	1	13%
prenatal care/WIC	1	13%
access to STD counseling	1	13%
support groups	1	13%
translation	1	13%
transportation	1	13%

*Projects provided multiple services, therefore column totals exceed 100%.
Note: It is unclear whether one project is providing access to services, therefore, it was excluded from this table.

Of the nine projects site-visited in Phase II, seven provided access to health-related services. These seven projects provided access to a total of 22 types of services, almost all of which were provided by the grantees themselves. **Note: the activities defined as "services" are not *medical assistance*, but services that link people to medical assistance**, such as screening and case management.

Together, the seven projects that provided such services provided them to *at least* 6,335 individuals within the target populations at the time of the site visits. Due to the fact that these projects are ongoing and may not have reached the end of their funding period, and because not all projects reported the total number served, this number is a minimum. In addition, the mechanisms for recording data at the various projects often did not capture complete numbers. Thus, the total served by the end of the project period will be considerably higher.

Sixty-four percent of the types of services offered by the nine FY 1995 grantees *had not been accessible to the target population prior to the OMH-funded project.*

LEP clients were recruited through a number of methods ranging from television to word of mouth. Clients were most commonly recruited by outreach services (6 projects, 86%), referral from other agencies (5 projects, 71%), and flyers or pamphlets (5 projects, 71%) (See **Table 3-8)**

Table 3-8
Strategies Used to Recruit Clients for OMH Grant Services
(Phase II Grantee Sample)

Recruitment Strategies	Number of Projects Using Recruitment Strategy	Percentage of Projects Using Recruitment Strategy*
flyers or pamphlets	5	71%
outreach	6	86%
radio or television announcements	3	43%
referral from other agencies	5	71%
walk in	4	57%
word of mouth	5	71%
other	3	43%

*Projects used multiple methods of recruitment, therefore column totals exceed 100%.
Note: One project did not answer this question, therefore, its data are excluded from this table

Increasing LEP Minority Populations' Knowledge of the Health Care System and of Preventive Health in General

Increasing knowledge of the health care system and of preventive health were typically interrelated activities, that were accomplished through a number of formats, including trainings and workshops, presentations, outreach, health education, home visits, health fairs, the dissemination of materials, and in the close interaction between patients and interpreters.

With respect to trainings, four of the 9 projects visited offered education/prevention training directed to the LEP populations (as opposed to trainings for health professionals). There were 11 different types of trainings for LEP populations conducted by these 4 projects.

The nine projects also created or adapted a total of 78 different types of materials (for all audiences, i.e., both health care workers and the LEP population), including pamphlets, brochures, newsletters, videos and others. Thirty-eight of these types of materials were clearly designated for the LEP population, and of these, 31 were pamphlets/brochures. The LEP population materials included the following examples:

- An API grantee developed four beautifully bound directories of local health care providers, with a focus on cancer, each in a different language -- Chinese, Vietnamese, Laotian and Khmer. This grantee also developed or translated 13 other pamphlets on health-related topics in the same languages.
- A mid-west grantee translated (into Spanish, and some into Vietnamese) a total of 10 pamphlets on dental care, well-baby issues, pregnancy, and available services.
- A grantee in New York translated into French seven different pamphlets on treatment and service issues related to HIV, STDs and TB.
- All the sites visited developed or translated a substantial number of pamphlets and brochures covering a wide range of health topics, from HIV/AIDS, to cancer, to dental issues, child development and maternal health, and other issues.

In addition, 4 of the types of materials were programs for radio and television (See **Table 3-9**)

Table 3-9
Materials Created for the LEP Population
(Phase II Grantee Sample)

Material	Number of Different Types of Materials
pamphlets	31
radio spots	2
television shows	2
newspaper articles	1
videos	1
other	1

Perhaps as important to target population awareness as any of the specific materials created, trainings provided, or outreach activities undertaken, was the knowledge gained from the ongoing personal interaction with health educators, outreach workers, interpreters, and other staff, and the increased confidence widely reported (in site visit focus groups) regarding the ability to handle the health care system. In the focus groups, increased patient knowledge and ability to handle their own care was a widely reported outcome, where LEP patients, through education sessions or in working with interpreters/advocates, began to ask more questions and undertake health care appointments on their own, or engage in preventive behavior -- for example with respect to diet or smoking. This has implications with respect to the cost-effectiveness of care. OMH-funded health educators and outreach staff are often key to this transition, because they themselves are typically known and trusted

in the community, and they are, quite simply, *there, and constantly involved in close personal contact that includes both informal and formal education and moral support.* For example, the Vietnamese health educator at one grantee was well-known for her dedication. She would call her clients to remind them about appointments, and to remind them to take medication. Many of these clients were older and had trouble remembering these things. Importantly, she constantly pushed her clients to overcome traditional deference and to ask or assert themselves when they had a question or need with respect to health care. And she motivated many clients at risk for cancer to seek help — to overcome the common attitude shared by many in Vietnam who were not wealthy that cancer was "automatically terminal" and patients essentially "waited to die."

Domain 5: Did the Program Serve as a Catalyst to Develop or Change Existing Health Policies at the Community Level?

AND

Domain 6: Did program findings/outcomes influence State/Federal Policies Targeting LEP Minority Populations?

Impact in this area varied greatly by project—particularly dependent on the involvement and orientation of the project director with respect to this arena. Nonetheless, several of the FY 1995 projects sampled showed significant impact on local and State policy. This impact was primarily focused on increasing awareness about bilingual/bicultural health issues among key constituencies, including professional organizations, health agencies, task forces, panels, and other such entities. Examples include the following:

- Staff at a Washington, DC grantee have participated in efforts to raise awareness about the need for interpretation services, particularly in light of the increased presence of managed care in the public health setting. Staff have appeared and presented testimony to local government hearings and other fora on this issue.
- Because of the OMH-funded language and cultural training provided at a large metropolitan area health department, the department as a whole has adopted a policy regarding the effective use of employees who complete the training, in part stating that completers may be asked to work in majority-Hispanic clinics (if they don't already) once per week. In addition, the employee union, which had initial misgivings about the training and its implications on job qualifications and preferences, now has developed -- in conjunction with the employer -- job descriptions that include a bilingual requirement, a bilingual proficiency exam, and criteria for bilingual designation. In addition, a number of other large agencies and private organizations in the metro area have requested the language/cultural training for their employees. These include the lead abatement program, HIV and TB testing services, the Red Cross, private health providers and hospitals, county hospital emergency services, and school health programs (who have experienced problems in communicating with LEP Spanish-speaking parents).
- The project director for a grantee in New York City is a member of the HIV/AIDS Policy Planning Group, representing the West African immigrant community. This is a key group in a very high-profile HIV/AIDS city. Generally, because of the influential role they have developed -- in part due to OMH funded activities -- this grantee has been involved in policy development surrounding female genital mutilation, policy and program development (with the New York City Department of Health and New York Task Force on Immigrant Health) concerning the issue of HIV-2 (a strain primarily affecting peoples

from West Africa), and general issues of language and interpretation with the Immigrant Health Task Force Language Working Group.

- As a result of her role on the OMH project, and her increased profile among a wide range of area providers, the project coordinator for a California grantee has participated in a number of policy making panels related to issues of access to care. These include: the California Wellness Foundation panel on cultural competency standards (for medical care) and the Medicaid Task Force of the California Health Care Interpreting Association—the latter related to developing culturally and linguistically appropriate performance standards/guidelines. In addition, several area health providers and hospitals have implemented policies regarding bilingualism, and guidelines for the use of interpreting services.

We did not find any impacts at the regional or national level for these projects. However, we might note the following trend: the one-year grants showed some policy impact at the community level; the three-year grants showed some at both the community, city and State level. More time may equate to more impact of this nature. Moreover, it may be difficult for projects such as these to make an impact at the national level. As discussed more fully in Chapter 5, this is where the OMH role is strongest, building on the lessons learned and collective experience of its grantees and educating the health care community about the importance of, and need for, bilingual/bicultural services -- as well as best practices for implementing such services.

CHAPTER IV

Summary of Study Results

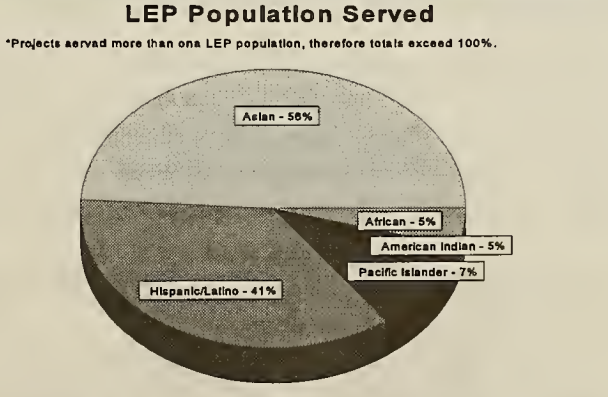
In this Chapter, we review the combined results of Phases I and II, discuss common implementation issues and barriers, and outline specific strategies and program components that were effective. Finally, we identify program components that are key to successful programs.

SUMMARY OF OMH BILINGUAL/BICULTURAL SERVICES DEMONSTRATION GRANT PROGRAM

The OMH Grant Program has funded three series of grants, encompassing 62 projects, for a total value of $4.75 million. In FY 1993, 12 projects were funded for one year each; in FY 1994, 35 one-year projects were funded; in FY 1995, 15 three-year projects were funded and are slated for completion in Fall 1998. The projects were located in 19 states and the District of Columbia and American Samoa. The study is a first attempt to gather comprehensive information about the implementation and impact of the OMH grant program. It has been carried out in two phases. Phase I involved the administration of a Mail Verification Survey and a Follow-up Telephone Interview to a sample of 32 of the 47 projects funded in FY 1993 and FY 1994. Phase II involved site visits to nine of the 15 FY 1995 (3-year) grantees. The study collected data in response to eight policy and programmatic questions (referred to as "domains"). For example, Did the program help build the capacity of community-based organizations to address access to health services for limited-English-speaking minority populations? Did the program increase the capabilities of health care professionals to address cultural and linguistic barriers to effective health care service delivery? Did the program increase access to health care for limited-English-speaking minority populations and their knowledge of and ability to negotiate the health care system?

Summary of Grantee Characteristics

The vast majority of the 32 projects (29, 91%) operated in urban locations. Another seven (22%) were located in rural areas and three (9%) in suburban areas. In addition, some projects operated in more than one type of location. Ninety percent of the grantees were nonprofit organizations; 5% were county health departments, and 5% were tribal governments. The target populations tended to be more disadvantaged than the community as a whole. Asians were the group most frequently served by all projects (56%), followed by Hispanic/Latinos (41%),



Pacific Islanders (7%), American Indians (5%), and Africans (5%). There were more than 14 specific ethnic groups served among the Asians, most frequently Cambodian/Khmer, Laotian, and Vietnamese, Mexicans and other Central Americans, and Salvadorans were the groups most frequently served among Hispanic/Latino populations.

Forty-three languages were spoken by the target populations served. Most frequently, these were Spanish (41%), Lao (39%), Vietnamese (39%), Khmer (34%), Chinese (22%), Hmong (20%), Thai (17%), and Tagalog (15%).

Two-thirds of the grantees served target populations of all ages (adults and children). For more than two-thirds of the projects, the OMH-funded activities were new to the grantee; for the remainder, the activities were an expansion of existing grantee activities (OMH-sponsored or in-house). More than half (53.3%) of the projects reported that project staff needed additional training to carry out project activities.

Needs assessments were conducted by 37 percent of the projects. Projects identified more than a dozen barriers facing the target population with respect to accessing health services. Most frequently, these related to:

- language/lack of translation materials and lack of language-appropriate information, signs, or brochures (95%),
- lack of awareness among target population (78%),
- lack of awareness among providers (76%),
- gap between target population's health practices and mainstream health practices (66%),
- a lack of health insurance or other benefits to cover costs (59%), and
- lack of money for medical expenses, transportation, and other costs (59%).

Projects identified an average of three goals and seven objectives each, for a total of 107 goals and 310 objectives. Some projects proposed many more, with one project recording 14 goals and another 20 objectives. Of all objectives, 211 (68%) were fully achieved; 69 (22%) were partially achieved, and 12 (4%) were not achieved. For 18 objectives (6%) the achievement level was not available. Seventy-eight percent of the Phase I projects fully achieved more than half their objectives. Fifty-six percent of the Phase II projects fully achieved more than 40% of their objectives; another 56% partially achieved more than half their objectives. Analysis showed that projects were more successful in fully achieving objectives that involved capacity building and the development and dissemination of materials than in achieving those that involved education and training and service delivery. Generally, the inclusion of unrealistic numbers of goals and objectives was an implementation problem that needs to be addressed.

SUMMARY OF MAJOR IMPACTS -- PHASES I AND II COMBINED

The OMH Bilingual/Bicultural Demonstration grantees were funded to step in and address the kinds of situations described above. Given the funding limitations, these projects achieved some notable impacts. Moreover, we cannot leave out the human element -- many of these community projects are staffed by people who have a tremendous dedication to their work and to their community. This in itself is a resource which should be given ample credit.

Building capacity: During and after the grant period, just over one-fifth of the grantees in the study sample generated additional funds to supplement OMH support in carrying out their project's activities. Over half the Phase I grantees reported that the activities developed with OMH funds were continued beyond OMH funding, thus these projects served as ongoing resources in their local communities. Nineteen percent of the Phase I grantees reported that specific policies or procedures had been adopted as a direct result of OMH grant activities. The new policies/procedures adopted by those organizations included things such as:

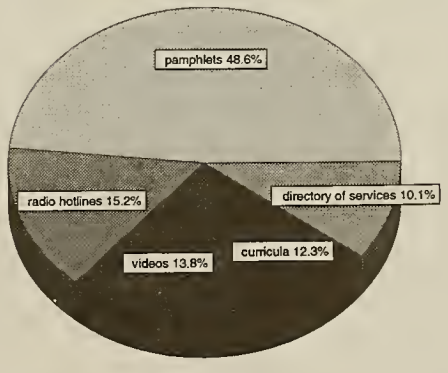
- requiring staff training,
- developing long term plans for integrating cultural competency into all aspects of the organization,
- developing a culturally acceptable tribal plan for the long-term delivery of HIV/AIDS and related health risk education, and
- establishing the procedure that all emergency-room referred clients receive a clinic reminder call for follow-up treatments.

Twenty-eight percent of the Phase I grantees reported that either their organization or staff from their organization had become involved in community coalitions or committees as a result of the OMH project. Thirty-one percent of Phase I grantees reported that as a result of OMH funding, activities developed during the grant project had been integrated into other programs. For some, this meant that curricula developed with OMH funding continued to be used and was adopted by other organizations in the community. Staff training continued in some sites. In other sites, the use of translation services by hospitals and health care providers was increased.

In addition, many grants -- particularly the longer three-year grants (sampled in Phase II) -- built reputations in their communities, and even at the statewide level in some cases, for providing/advocating LEP minority health services. Some grantees became known resources: "if you need help with interpretation, you can go to (PROJECT)." Staff capabilities and links to the community were typically strengthened as well, an effect more pronounced with longer grants. Several projects served as pilots, in the sense of leading to more expanded funding or incorporation into other activities.

Increasing Provider Awareness And Capacity: From all OMH Bilingual/Bicultural grantees sampled in Phases I and II, at least 5,068 health care professionals have participated in training for providers (by end of FY 1995 grant period). A total of 47 types of trainings were held for health care professionals, most often for doctors, nurses, and community health workers. Other health care workers who were trained included health educators, outreach workers, physician's assistants, interpreters, midwives, case managers,

Materials Most often Selected



emergency room staff, and many other types of health care workers. In addition, 12 other types of trainings were held for interpreters and others.

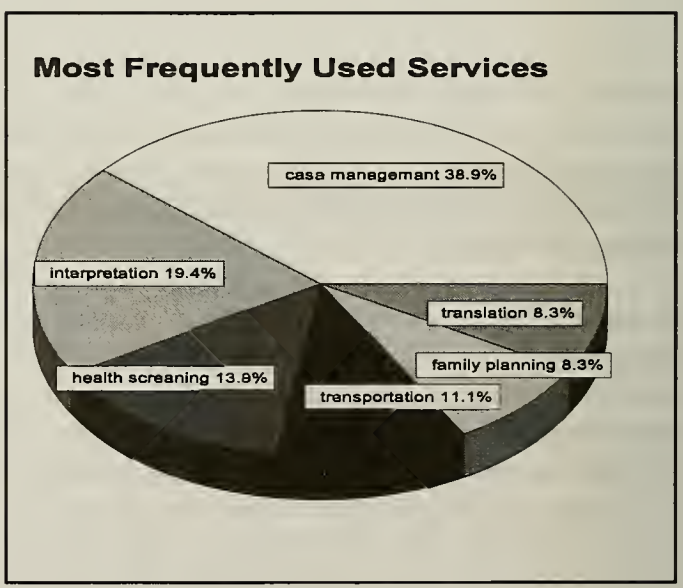
Projects developed and/or adapted a total of at least 186 distinct types of materials, most often pamphlets, radio spots, videos, curricula and directories of health care and social services staff.

In addition, other key impacts reported in this domain included: positive changes in health provider attitudes with respect to serving LEP patients; increased provider knowledge of specific cultural circumstances (refugee experiences, traditional health practices); increased provider knowledge of and capability to work with interpreters; and increased provider ability to handle emergency and crisis situations with LEP populations. As Phase II projects are completed, more impacts of this nature may occur.

Increasing Access to Services: As mentioned in earlier sections, the OMH grantees did not provide direct medical services (treatment) per se. Many, however, provided intermediate or enabling services designed to move LEP individuals into health care -- case management, health screenings, outreach and referral, and interpretation are examples. The use of the term "services" in this report refers to these kinds of enabling activities.

For the combined Phase I and II sample of grantees, a minimum of 13,035 LEP clients received (intermediate) services that increased their access to direct medical services. These services most often included case management, interpretation, health screening, transportation, access to family planning, and interpretation, and others that served as the entry point for direct medical services.

As described under the next domain, increases in LEP population awareness (about prevention and health) and ability to negotiate the health care system also increased access to services, *because these LEP individuals are more likely to be proactive and seek services where they would not have before, particularly for preventive care such as prenatal checkups.*



Increasing LEP Population Awareness About Health Prevention And Knowledge of The Health Care System: This was probably one of the strongest impact areas for both Phase I and II grantees. LEP population awareness was increased through a wide range of specific activities, including outreach, health fairs, education sessions, home visits, and other modalities. It was also increased via the often close interactions between patients and interpreters, or between patients and health educators. LEP clients often had to rely on these individuals for a great deal, and to discuss highly personal or confidential issues with them. In addition, LEP clients often reported an increase in confidence about how to obtain care, and on what it means, for example, to have a mammogram.

manner, but they were commonly reported where the question format allowed for open-ended explanation -- particularly during site visits to the Phase II (3-year) grantees. While the site visit format allowed for much more data of this type, similar impacts, on a smaller scale, were also reported for the FY 1993-94 (Phase I) grantees.

Impact on Policy: The impact in this domain varied clearly by length of grant, not surprisingly. The FY 1993-94 grantees were not in place long enough to make any policy impact outside their programs or immediate surroundings. On the other hand, the FY 1995 grants have thus far showed more policy impact at the local and sometimes state level. This impact came in the following ways:

- Changing procedures and policies of local or regional health providers—usually to incorporate bilingual designations or requirements for employment and/or staff advancement; institutionalizing the necessity of language competence.

- Through participation in task forces, commissions, and other deliberative bodies, involvement in the development of standards or guidelines with respect to cultural and linguistic appropriateness in health care. *This, we would like to stress, is a key area in which OMH and its grantees could have a more visible impact.*

EFFECTIVE PROJECT COMPONENTS AND STRATEGIES

As elaborated further in Chapter V, Recommendations, the OMH grantees have developed a rich variety of strategies and approaches for addressing health access needs of specific LEP populations. The experience of these projects is an enormously useful resource in support of further efforts in the field. Moreover, the implementation of these projects has resulted in significant data on effective implementation strategies and project components. A selection of these from the Phase I and II projects are highlighted below:

What Are Keys to Successful Project Implementation?

✓ Simplicity helps effectiveness. Study results indicated that projects were more effective when program scope was realistic; when the number of goals/objectives, number of services provided, or number and variety of communities served was kept to manageable levels. Otherwise, it is too easy to become overextended, because the process of working closely with specific communities is time consuming.

✓ Consistent attention to evaluation is difficult for small, community-based programs. In this respect, agencies can benefit by developing a permanent relationship with a local college or university to assist with ongoing evaluation and needs assessment.

✓ Resource and other limitations can be a barrier. In this study, projects that made a concerted effort to link up with local task forces, health organizations, community health coalitions and hospital committees leveraged more resources.

✓ Staff retention can be an obstacle for small community-based programs: Projects need to be creative in recruiting and retaining qualified staff who are bilingual, such as developing nonmonetary incentives for staff who are qualified and have an adequate health background.

- ✓ For the OMH program as a whole, it was apparent that sequential funding of grants can help build a cumulative expertise at the grantee organization; for example, a video developed in one year can be used as a training vehicle in subsequent years -- as part of a subsequent grant to the same organization for training.
- ✓ Generally, projects are effective when they have credibility, respect, and presence in the community. There is no shortcut for this -- it takes time, and requires consistency.
- ✓ The credibility of community program staff can be a key factor in relationships with providers; therefore, projects need to take advantage of any opportunities to obtain certification or professional designations for medical interpreters and other staff.
- ✓ Public health agency grantees will often have to address a range of bureaucratic obstacles. Project experience strongly suggests the need for such grantees to enlist the cooperation of a top-level representative who can broker departmental rivalries. This person is crucial in obtaining resources and overcoming turf issues.
- ✓ Many of the activities involved in the process of increasing access to health care for LEP populations are complex and labor-intensive. Project or program directors, if they are not able to devote a large percentage of time to these activities, should designate a dedicated project coordinator to the project to handle the multiplicity of day-to-day activities.
- ✓ Training is best when it is not a one-time event: programs for health provider staff are most effective if they are followed up by booster sessions or other followup activities.
- ✓ Program staff working with clients concerning serious diseases such as HIV/AIDS and cancer should have crisis training, because they are often called upon to handle such situations.

What Were the Most Effective Program Components?

- ✓ Generally, the use of interpreters was highly effective in responding to the LEP population's need to obtain health services -- particularly since, for the most part, interpreters also tended to serve as client escorts, advocates and health educators.
- ✓ While interpretation services were effective, a common obstacle concerned the relationship between interpreters and health providers; some projects addressed this by offering interpreter training that sought to include both providers and interpreters to foster communication and rapport.
- ✓ Components tailored to the needs of specific populations worked well: For example, home visitation was the most effective method of health education for Southeast Asian women.
- ✓ Personal relationships are essential in promoting successful health behavior change with LEP populations; projects that utilized health educators and interpreters who regularly accompanied patients through the process were most effective in engendering patient awareness and confidence in negotiating the health care system.
- ✓ Health provider staff training program components often encounter problems of attendance and resistance: These were minimized when training for health care providers was incorporated into the job requirements and attendance was required and paid for.

- ✓ Projects that trained health care providers on cultural awareness and interpretation also faced resistance. Adding a marketing component was one strategy that proved effective. Such a component could employ newsletters or other information sent to providers that:
  - raises provider awareness of the pitfalls (and potential liabilities) of mistranslation and language barriers, and
  - outlines the links between cultural beliefs and health behaviors.

- ✓ Increasing awareness through media materials was useful, especially when tailored or targeted to specific situations. For example:
  - radio spots may reach a wide audience in a cost-effective manner, and
  - videos may be most effective when used with a trainer in smaller, interactive sessions.

- ✓ For study grantees, capacity building activities and materials development/dissemination were more successful (in terms of meeting project goals and objectives) than activities focusing on education, training and service access. However, this may simply mean that more resources and technical assistance may be required to successfully implement these latter services, or that project goals in these areas tended to be unrealistic.

COMMON IMPLEMENTATION ISSUES AND BARRIERS

Phase I and II grantees experienced a number of common implementation barriers. These included:

- **Difficulties in finding and retaining bilingual staff who were also qualified as health educators, interpreters, etc.** Many projects in all grant years experienced difficulties in recruiting and retaining staff at all levels to carry out their LEP projects, which often led to delays in implementing project activities. Staff for these projects require a complex mix of background and training. This problem was described eloquently by the respondent from a grantee health center: "We had difficulty in recruiting candidates that were equally qualified in language and cultural competencies. It was necessary to find candidates who were comfortable in their ethnic language as well as English, were acceptable to their community as a bridge between western medicine and traditional practices, and felt comfortable educating members of their ethnic group as well as western medical providers." In addition to the cultural and language requirements, many of these projects required staff who also had significant subject matter expertise. A community center working with Southeast Asian immigrants found it "extremely difficult to find a person who has both community ties and a health background. There are few health professionals and paraprofessionals in the Lao and Cambodian communities; of them, most are totally overextended." Finally, a grantee in New York noted that finding all these qualifications in someone who also has no unresolved immigration status issues is even more difficult. But cultural competence of staff is key, explained another grantee: "This element of cultural competence, then, is central to success, since refugee families are won over to this system by the feeling that there is someone who truly understands them in the care system, and that this knowledge will carry some weight in the overall care system by which the patient is served."

- **Low salary levels.** For many projects, low salary levels were a significant barrier to hiring qualified staff once they had been identified, or retaining qualified staff for the entire grant period. As the respondent from an Asian Pacific Islander project pointed out " truly bilingual/bicultural Asians are easily able to find jobs with much higher pay and benefits while those interested in this wage range tend to be limited in English proficiency." A community center unsuccessfully attempted to address this problem by giving employees stipends for language abilities. The respondent from the center reported that "the incentive program was not effective as a means of retaining bilingual staff. The amount of money ($500 for full-time employees) was deemed insufficient to make a difference in an employees's decision of whether to stay at the center or seek employment elsewhere. Comments from Hispanic staff members indicate that a separate (higher) salary scale for bilingual employees would be more effective than a stipend."

- **Evaluation.** This is, of course, a perennial problem with small CBOs which have their hands full with the day-to-day needs and crises involved in operating such an organization. Projects serving limited English speaking populations may face another layer of difficulty in program evaluation. As a grantee staff member pointed out, "we found that Asian seniors had trouble understanding the concept of understanding evaluation. We had to educate them about what evaluation is." *Clearly, to overcome some of these misunderstandings, simple, clear forms, standardized and translated would be recommended, along with a higher degree of monitoring and technical assistance for evaluation.*

  In addition, certain kinds of evaluation modalities, such as customer satisfaction questionnaires, do not reflect actual experience: Asian participants may be reluctant to provide any negative feedback on program activities "because of their tendencies to achieve group consensus, harmony, and moderation." An API project needed to have a community leader explain to the group the purpose for the evaluation. Generally, evaluation can be a controversial process, especially in immigrant communities. "Providing health care to refugees is often a socially and politically charged issues, especially when we are dealing with low income populations. We could not subject providers to too rigorous questioning about their practices toward refugees without some declining to participate out of fear of community response." (A small community association).

  Finally there is the issue of resources and time. Many of the projects sampled in Phase I and II did not have sufficient staff time or expertise to conduct evaluation; or they did not have computer data software and other basic technologies. So, data was collected haphazardly, or collected by hand. Some projects retained outside evaluators, but these relationships did not always remain stable throughout the grant period. The most successful evaluations often occurred when there was in-house expertise and an institutional habit of collecting data and maintaining records or a good, ongoing relationship was established with an outside evaluator, for example, at a local university.

- **Funding and length of project.** This was much more of an issue with the FY 1993-94 grantees than with the current (FY 1995) grantees, for obvious reasons. One year grants are simply not enough time to make an attempt to address the broad needs faced by LEP minority communities. At the same time, since needs and expectations are high, many projects try to do too much in

that short period of time. What did prove useful, however, is that some projects developed something -- for example, a video -- under the one year grant, and then used that in a follow-up grant or used it as the basis for an expansion of activities. In such cases, the one-year grant was akin to "prototype" development funding.

- **Grantee - OMH relationship.** While in many cases this relationship was problem-free, a commonly-expressed sentiment was that projects experienced a general lack of involvement by OMH, either to provide guidance or technical assistance, or to monitor progress. More direct and ongoing interaction would have been beneficial. One grantee expressed disappointment that the meeting for projects ostensibly funded under this initiative was not held, saying that such a meeting could have oriented grantee staff unfamiliar with administrative regulations and policies of OMH grants. Another grantee suggested that the reporting requirements (4 quarterly reports plus a final report) were burdensome for a 12 month project and that reports at 6 and 12 months might be adequate. Finally, another grantee reported a misunderstanding with OMH regarding funding and with respect to a small independent research project that was to be conducted at their site.

- **Project structure; too many goals and objectives.** Many projects, under the pressure of competition for funds, or simply from lack of experience, created project frameworks that were overly ambitious with respect to goals and objectives, and that left no room for the kinds of delays and barriers that almost inevitably arise in such projects. Too many goals and objectives tends to translate to an overextended staff who may end up worrying about "making the numbers" vs. working through barriers and providing a quality service or product. In addition, many of the goals/objectives as written are not easily measured, hampering evaluation or rendering ambiguous the meaning of the evaluation.

- **Other issues.** Issues already discussed in Chapters II and III, but which arose as implementation barriers, also include: non-literate populations for whom there were few resources; health provider resistance to trainings; and issues of bureaucratic politics, ethnic competition (regarding funding), and intra-ethnic conflict.

- **Specific cultural issues.** A number of culturally-specific issues arose in reference to implementation. These included:

  - Support group sessions may not be effective for Asian populations. It is "culturally foreign" to gather with people who are not part of one's own family to talk about personal issues.

  - A wide range of *intra-ethnic conflicts* were observed. These are not commonly discussed as *inter-ethnic conflicts*, but represent strong implementation barriers. Some examples:

    a) Conflict between Hispanics who have recently immigrated and those who have been in the U.S. for a long time -- this comes up in resentment that the "new immigrants" don't speak English while many of the long-term residents do, and in other ways.

    b) Conflict between Hispanics of different classes or from different regions.

c) Conflicts or misunderstandings especially between Southeast Asian health professionals and their patients -- some professionals, especially if accustomed to traditional hierarchical relationships in the home country (in which doctors have great authority), do not expect and are not pleased to experience questions or discussions from patients about diagnosis or treatment issues.

d) Conflict between Vietnamese and Amerasians -- in one project that had hired a (Vietnamese) Amerasian staff found that subtle and open conflicts and hostilities appeared, based on prejudices against Amerasians.

- Individuals from Latin America who are of native Indian descent -- Mayans, Zapotecs, Mixtecs and other native Indian peoples from Mexico and Central America are often classified as Hispanic, yet this designation is not accurate with respect to language, and they typically do not speak Spanish (or speak it well).

- Latino men who have sex with men may be difficult to contact with respect to outreach and education, because these individuals do not necessarily identify with the "white" gay community, nor do they always identify themselves as gay.

- Printed materials are not necessarily the best means of imparting information. For Guatemalan Indian peoples and other low literate LEP clients, oral methods (e.g., storytelling) are more effective. Given this, it may be worth assessing the intended audience and utility of the large number of pamphlets produced by OMH grantees.

CHAPTER V

Recommendations

Overall, the **OMH Bilingual/Bicultural Service Demonstration Grant Program** has proved to be a significant force at the local, community, and sometimes State levels with respect to the process of increasing access to health care for LEP minority populations. While precise impact and process data has been difficult to collect on a comprehensive and consistent scale, impacts over many dimensions have been shown, as outlined in this report. Moreover, it is DSG's strong belief that OMH should exercise a more proactive management over program implementation, products, and outputs so that the Bilingual/Bicultural program as a whole could be of substantial assistance to OMH in furthering its larger goals. These include policy development vis-a-vis the range of Federal agencies and organizations supporting the provision of health care to minority populations.

The following recommendations, based on the data collected in this study, are directed towards OMH and are designed to contribute to this process. The first five recommendations relate to specific ways in which OMH could improve Bilingual/Bicultural program functioning and effectiveness; the other seven recommendations are more comprehensive suggestions for the program and for OMH itself.

RECOMMENDATION ONE: Provide Better Technical Assistance to Grantees on Setting Goals and Objectives

Many grantees wrote too many goals and objectives, hampering their ability to fully achieve any one of them. This was especially true for the FY 1993 and 1994 grantees, given the short one-year time frame for their projects, but it also was true for the FY 1995 grantees to some extent. It is almost a given that implementation problems will arise, and the more flexibility that exists within a particular program, the more resources will be available to overcome the problem. One good example—a community clinic experienced a number of problems in attempting to recruit health providers for their interpreter training. Fortunately, they were not so overburdened by a long list of goals/objectives and were therefore able to devote time and resources to developing a strategy for overcoming the provider resistance—a strategy that proved not only very successful, but is replicable. Thus, OMH needs to assist grantees and potential grantees in structuring programs (even at the application stage) that have realistic goals and objectives.

RECOMMENDATION TWO: Provide Better Technical Assistance to Grantees Concerning Evaluation

First, given the modest levels of funding, a surprising number of grantees did collect evaluation data of some sort. Many, however, did so using informal or haphazard methods and technologies. Some did not have automated data collection processes. Some collected data using questions that were vague, leading to data of questionable meaning. There also was little in the way of comparable data

collection methodologies across sites. Occasionally, data was not collected at all. This is, in part, an issue of resources. Most community-based programs are so overburdened by their daily challenges that collecting data becomes a "back burner" priority. Recommendations to address this situation include:

- OMH should consider providing more direct help in evaluation and data collection, or foster arrangements with local colleges/universities;

- OMH should consider providing grantees with a tailored database software package, on disk/CD, through which they can enter and process their data in a format that is standardized, as much as possible, across grantees. Some minimal training on software use also should be provided; and

- if provision of automated software is not a realistic possibility, provide grantees with a set of data collection forms. *We note that the evaluation instruments developed and used for this study could be a basis from which standardized data collection tables could be developed.*

RECOMMENDATION THREE: Provide More Direct Assistance to Grantees in Dissemination and Networking

Once again, the OMH grantees have truly developed a wealth of materials and strategies, and they have a wealth of widely varied expertise in working with LEP populations. This expertise needs to be shared. OMH could help to share this expertise by sponsoring meetings, panels, conferences, and special journal editions, but also by *facilitating contact* between grantees and other organizations and associations through which these grantees could do the disseminating themselves -- for example, OMH could circulate bulletins or a newsletter (to grantees) that features dissemination strategies. Another dissemination route is collaboration with other Federal programs such as the Area Health Education Centers (AHECs) funded by HRSA. One project, in fact, had already begun to collaborate with their local AHEC.

OMH grantees would also benefit greatly by opportunities to network *among themselves*, to share best practices, strategies, and resources. OMH could create such opportunities through:

- new and old Project Director technology transfer meetings;

- annual grantee conferences;

- better use of Internet technology; and

- routine conference calls, with groups of grantees, with OMH, or with technical specialists where useful.

RECOMMENDATION FOUR: Provide More of a Support/Facilitator Role in Difficult Situations

There were several instances where OMH grantees operating within a large public agency had to confront bureaucratic obstacles and rivalries. These kinds of barriers can be mitigated with a small amount of contact between OMH and a higher-level individual within that agency. Something as simple as a letter on agency letterhead requesting high-level support would be very helpful. When the program has support from a higher-level official, its chances of success are much better. Letting grantees know that OMH support is available, and keeping in regular contact with grantees in order to be aware of such obstacles, is important for grantee performance. In short, OMH has an important role to play in helping its grantees negotiate the organizational or structural setting within which they must operate. Providing this assistance helps further the overall OMH goal of increasing access to care.

RECOMMENDATION FIVE: Develop and Disseminate a Best Practices Document for Bilingual/Bicultural Health Care Access Programs

In part from information contained in this report, a Best Practices summary could be developed and disseminated not only to OMH grantees, but to programs serving similar populations funded by other agencies. The OMH projects reviewed in this study provided a wealth of information about strategies that work and those that do not work. Based on these, some examples of what OMH could recommend include:

EXAMPLES OF BEST PRACTICES RECOMMENDATIONS

- Innovative strategies for training and utilizing interpreters: Two community health centers both developed unique and effective strategies for increasing the capability of health providers in working with interpreters, and in overcoming their resistance to participation in trainings -- one developed trainings specifically designed to bring interpreters and providers together; the other developed a newsletter and bulletins on interpretation and cultural issues designed both as an information and marketing tool (with respect to participating in trainings) for health providers.

- Implementing programs in the public health agency context: A large metro-area health department secured staff involvement in their (OMH-funded) language and cultural awareness training by:
  a. gaining the imprimatur of a top-level public health commissioner;
  b. treating participation in the training as part of the job, so that it was provided during paid work hours; and
  c. working with the employees union to establish an official benefit and certification for those who completed the training and could pass a bilingual examination.

- Improving health provider awareness of immigrant background as it may affect health care: A community clinic in Washington, DC developed a one-page cultural background form that is designed to be provided to doctors/health providers working with Central American refugee

patients. The form gives the provider background about the kinds of crises situations (war, flood, famine, etc.) the patient may have experienced, the nature of his/her immigration experience, current social networks, use of traditional medicines and procedures, and other factors that the provider would not likely know, but would find of immense value in developing and supporting the provision of appropriate care.

- Developing approaches for non-literate clients: A surprisingly large number of LEP population clients were low or non-literate. At the same time, many projects were engaged in developing pamphlets and other written materials which may or may not be useful to these individuals (depending upon format). OMH could foster the dissemination of methodologies developed by a number of grantees for targeting non-literate audiences -- videos, community discussion groups, etc. A special conference or publication could even be dedicated to this issue.

RECOMMENDATION SIX:	Consider a Mix of Grant And Contract Types That Make Better Use of Resources

Given the problems many grants had in finding and retaining staff, as well as problems concerning adequate funding, it may serve the overall program well, and be cost-effective, to have several types of grants that are funded in this area:

- **Introductory or Pilot Grants.** These could be small, and short-term, with the explicit purpose of developing and testing out a training modality, material type, or activity. The funding would be limited, but so would the grant purpose, thus eliminating the problem of trying to do everything on a sparse budget. Grantees who completed/tested their particular activity would then be eligible for a full grant, and would be able to apply for the full grant through an expedited process. This process is somewhat akin to the Small Business Innovation Research grants operated by the National Institutes of Health and other agencies.

- **Full or Regular Grants**. These would be full, three-year grants to implement a mix of activities designed to increase access to health care, with a budget sufficient to attract the necessary staff, and to conduct a reasonable evaluation -- or, *if the projects do not conduct the evaluation, OMH should contract with a general or cross-site evaluator to do so.*

In addition, to ensure consistency and quality of evaluation, as well as to assist with program development and implementation, *OMH should consider retaining an ongoing source of technical assistance and evaluation for its grantees.*

RECOMMENDATION SEVEN: Develop a Technical Assistance Capacity for Culturally - Specific Program Implementation and Expand OMH Functions to Improve Dissemination of Grantee Materials

So many valuable materials have been created by OMH grantees, yet there is little evidence that the materials have been cataloged and utilized in a way that maximizes their utility with respect to the overall community of health providers. In fact, once developed and used for the limited time period of the grants, many of these materials, and strategies as well, have almost been set aside. Yet, it is from this base of materials and strategies that OMH could strengthen its hand in making recommendations for Federal or agency policy. Therefore, we recommend the following:

- OMH should take on more dissemination functions;
- OMH should expand its efforts towards a more proactive technical assistance role, linking technical assistance providers with programs or agencies needing assistance.
- Grantee staff might serve as technical assistance providers in some cases (through the Resource Persons Network), to help other programs implement a strategy or component that they themselves had developed. This not only helps in disseminating and implementing best practices in the field, it also helps to build the capacity of those grantees who provide technical assistance.

RECOMMENDATION EIGHT: Building on the Bilingual/Bicultural Project Experiences, OMH Should Bring its Expertise to Current Managed Care Issues in Public Health

With limited English-speaking and other minority populations, in particular, it became very evident that the issue of cultural competency and linguistic appropriateness of care were key -- and that many of the OMH grantees are very involved in ensuring that health care is available and competent within these dimensions. All activities associated with this process—developing materials, providing interpretation services, training health providers on cultural awareness and on the use of interpreters, translating and developing forms, serving as patient advocates and health educators—are important. Moreover, several grantees have become directly involved in the development of local and/or state standards of care or guidelines used by managed care organizations. Based on this expertise, we believe that OMH could have an informed and effective voice in the managed care debate, and that *it is an arena in which OMH expertise would be of considerable value in advancing the general improvement of health care for minority populations.* For example:

- OMH should disseminate recommendations on standards of care to the National Committee on Quality Assurance (NCQA), which develops and disseminates the HEDIS standards.
- OMH should make its expertise available to Managed Care Organizations.
- OMH should work closely with HRSA and other Federal agencies involved in standards and guidelines.

RECOMMENDATION NINE:	**Support or Facilitate the Certification and Professional Development of Interpreters and Community Health Workers**

A common experience among interpreters and community health educators was the lack of credibility given to their work by credentialed medical professionals, even when those same professionals used their services extensively. For this reason, OMH should actively support and promote, among its grantees as well as among relevant professional organizations , the certification of interpreters and health educators insofar as such certification is available. OMH should use its state and other contacts towards this end. Based on our experience in this study, we believe that such credentials are increasingly available -- especially for (medical) interpreters -- from national/regional interpretation associations.

RECOMMENDATION TEN:	**Partner With Other Federal Agencies and Private Foundations Who Are Working Toward the Improvement of Health Care for LEP Minority Populations**

At least one project has already collaborated with a HRSA-funded Area Health Education Center. In other situations, OMH-funded activities dovetailed very closely with other activities grantees were undertaking that were funded through Ryan White or the Centers for Disease Control and Prevention. A number of private foundations, such as the Robert Wood Johnson and Kellogg Foundations, may be engaged in or interested in health access issues for LEP minority populations as well. It therefore makes sense for OMH to actively seek partnership and collaboration opportunities. It also makes sense for OMH to promote grantee linkage to such activities and programs. Finally, OMH should seek to have the expertise it has gained regarding multicultural populations disseminated to organizations, such as the American Medical Association, which have influence on the content of medical school curricula.

RECOMMENDATION ELEVEN:	**OMH Should Use its Expertise to Leverage the Involvement of Other Agencies and Entities in Extending Health Care to LEP Populations**

Evidence from the study suggests that in managing the LEP projects, OMH has helped health care professionals understand the language and cultural requirements of LEP populations with respect to accessing services. No one can deny that language absence is a barrier to accessing health care. This body of knowledge can be used by all government health agencies and in the private sector to better serve their clientele. In sharing this knowledge with other agencies, OMH not only brings to the table the mandate to serve the underserved, but also the mandate to do so with well-established practices and competencies. These practices are transferable across health and social service areas affecting the fabric of the nation's communities, and are also highly applicable to the implementation of specific initiatives, such as the President's Race Initiative.

RECOMMENDATION TWELVE: **In the Grant Review Process for Programs Similar to the Bilingual/Bicultural Service Demonstration Grant Program, OMH Should Consider Key Factors that This Study Has Shown to Contribute to Program Effectiveness:**

1. **Does the applicant have a demonstrated willingness to organize and collect data on the project that is realistic and useful.**
2. **A stable organizational structure and funding record to attract and retain competent staff.**
3. **A project director with a strong community base and presence in organizations that deal with the general health issues beyond the community so that they can advocate and leverage additional resources for the community.**
4. **Willingness to work with non-traditional sources and program ideas, where, if successful, the practice can have great potential for a specified population.**

Some of the most highly successful projects reviewed in the study were both close to the community and influential with respect to health issues in the wider community. They had the capability to reach beyond the immediate LEP community but to link up with networks of organizations and providers that dealt with the broader health issues. For example, on the issues of HIV/AIDS and cancer, we found that several project directors were able to work within task forces and policy-making bodies and became the voice of their community within those organizations.

REPORT APPENDICES

•For full copies of Report Appendices A-C contact the OMH Resource Center at 1-800-444-6472

•See following pages for listings of Fiscal Year 1993-1995 Grantees

A Study of the Implementation of OMH's Bilingual/Bicultural Service Demonstration Grant Program List of Projects Surveyed or Visited

1993-94 Grantees in pilot survey (N=4)

Asian Americans for Community Involvement
Dallas Multicultural Alliance (see note)
United Cambodian Community
Vista Community Health Clinic

1993-94 Grantees in sample survey (N=29)

Alivio Medical Center
Asian American AIDS Services
Asian Counseling and Referral Service
Asian Health Services
Asian Pacific Development Center
Asian Americans for Community Involvement
Bridgeport Community Health Center
Cambodian Association of America
Cambodian Association of America
Cherokee Nation
Chinatown Action for Progress
Concilio Latino de Salud
Gandara Mental Health Center
Guatemalan Center
Hispanic AIDS Committee
Hispanic Health Council
Hmong American Community
Indochinese Community Center
Kalihi-Palama Health Center
Kalihi-Palama Health Center
La Frontera Center
La Clinica del Pueblo de Rio Arriba
Latin American Youth Center
Mary's Center
Mary's Center
Mississippi Band of Choctaw Indians
PROCEED
Wausau Area Hmong Mutual Association
Wausau Area Hmong Mutual Association

Note: Dallas Multicultural Alliance 1993 was dropped from the sample for the final report due to significant inconsistencies in their data which could not be resolved because the grantee has gone out of business.

1993-94 Grantees not part of the sample (N=13)

Asian and Pacific Islander Wellness Center
Asian Counseling and Referral Service
Association of Asian Pacific Community Health Organizations
Cambodian Community of Greater Fall River
Central American Refugee Center
Khmer Health Advocates
Koryo Health Foundation
Metropolitan Athletics Congress
Midwest Migrant Health Information Office
Multicultural Area Health Education
New Mexico Mutual Assistance Association
The Cambodian Family
Vietnamese Association of Illinois

1995 Grantees that received site visits (N=9)

African Services Committee, Inc.
Asian Americans for Community Involvement, Inc.
Asian and Pacific Islander Wellness Center
City of Chicago Department of Health
La Clinica del Pueblo
St. Joseph's Hospital
Union of Pan Asian Communities
Vista Community Health Clinic
Wichita-Sedgwick County Department of Community Health

1995 Grantees that did not receive site visits (N=5)

American Samoa Department of Health Services
Mary's Center for Maternal and Child Care
Midwest Migrant Health Information Office
Special Services for Groups
The Cambodian Family

Grand (Total N=60)

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Public Health Service ■ Office of Minority Health ■ 1-800-444-6472

OFFICE OF MINORITY HEALTH RESOURCE CENTER

BILINGUAL/BICULTURAL SERVICE DEMONSTRATION GRANTS FISCAL YEAR 1993

ARIZONA

Concilio Latino de Salud, Inc.

P.O. Box 1032
Phoenix, AZ 85021
PHONE: (602) 506-6787
FAX: (602) 506-6896

TITLE:
Optimal Ways to Deliver and Obtain Medical Services

PROJECT DIRECTOR:
Dr. Elizabeth O. de Valdez

GRANT NO.:
D56MP93069-01

TARGET POPULATION:
Asians, Hispanics

LANGUAGE:
Chinese, Spanish

Concilio Latino de Salud, Inc., proposes to establish a partnership among four agencies providing health care and educational services Concilio Latino de Salud, Inc., proposes to establish a partnership among four agencies providing health care and educational services to Hispanics and Asians. The project would address the training needs of professionals, paraprofessionals, and the lay public in the target communities. The goal of the project is to increase the capacity of all three groups to communicate more effectively across the existing linguistic and professional barriers.

The project would allow for the selection of 40 professionals who would receive instruction in Spanish medical terminology and culturally-related training. In addition, 18 to 20 Hispanic and Asian instructors would be trained to teach English medical terminology to 150 monolingual and limited-English-proficiency individuals. The project also would provide for the development of the curriculum on audio tape and distribution to another 100 members of the target communities.

CALIFORNIA

Asian Americans for Community Involvement of Santa Clara County, Inc.

232 E. Gish Road, 2nd Floor
San Jose, CA 95112
PHONE: (408) 452-5151
FAX: (408) 452-4620

TITLE: **Asian Seniors Health Project**

PROJECT DIRECTOR:
Ms. Cherry Wu

GRANT NO.:
D56MP93033-01

TARGET POPULATION:
Asians

LANGUAGE: Chinese, Vietnamese, Cambodian, Laotian, Lao-Mien, Filipino, Korean

Asian Americans for Community Involvement (AACI) proposes a culturally tailored project to reduce the incidence of serious illness among low-income Asian elderly (60 and older) and to encourage and enable seniors to become active in managing their own health. The target population is limited-English-speaking Chinese, Cambodian, Vietnamese, and Laotian elderly in Santa Clara County, which has experienced a growth in Asian population from 4,800 to 22,700 (1980-1990), primarily due to immigration. The specific target population of Asians 60 and older has grown from 3.4 percent of the county's elderly population to 12.45 percent during that period. Of these seniors, 42 percent are linguistically isolated.

The project focuses on bilingual and bicultural health education services, including regular health screenings; classes on understanding Western medical practices and on coping with disease, nutrition and exercise, and outreach.

Project objectives are to serve 1,000 low-income Asian elderly clients within 1 year and to provide biweekly health lectures and screenings, quarterly health classes, support/education groups for care givers and the infirm, and case management services. Additional objectives are to encourage community participation through outreach and to acknowledge in all project efforts Asian cultural beliefs, while facilitating clients' use of the existing health system.

The project builds on the experience of AACI as a nonprofit agency since 1973, specializing in advocacy and human services for Asians/Pacific Islanders in Santa Clara County. The proposed project will draw from AACI's large, multi-ethnic staff, collaborative

relationships with health agencies, and community organizations in effectively reaching the target population with a potentially replicable model program.

CALIFORNIA

Cambodian Association of America

2501 Atlantic Avenue
Long Beach, CA 90806
PHONE: (310) 988-1863
FAX: (310) 988-1475

TITLE: **SAFE/HARBOR PROJECT**

DIRECTOR:
Mr. Him Chhim

GRANT NO.:
D56MP93034-01

TARGET POPULATION:
Asians

LANGUAGE:
Cambodian (Khmer)

Southeast Asians are at especially high risk of having young children who are also at risk or disabled. Yet due to cultural, linguistic, and other barriers, including the shortage of Southeast Asian health professionals, Southeast Asian families i the Long Beach33 area may not seek the help they need.

The Cambodian Association of America (CAA) in Long Beach -together with the Harbor Regional Center of Los Angeles, which contracts with the State of California -- proposes a SAFE/HARBOR project that would initially hire and train one full-time bilingual/bicultural Cambodian case manager and one part-time Cambodian health educator. The case manager would provide culturally and linguistically appropriate medical case management, primarily for Cambodian families at the Harbor Regional Center, and the health educator would make presentations to families and service providers. Data on families' health status and services provided to them would be added to similar data in San Diego to assess health needs and the relative effectiveness of services offered to Southeast Asians. Ultimately, the CAA would like to extend the project's services to other Southeast Asians, demonstrate the feasibility of bringing paraprofessionals into medical case management, and extend its services further into Southern California.

CONNECTICUT

Hispanic Health Council, Inc.

96 Cedar Street
Hartford, CT 06106
PHONE: (203) 527-0856
FAX: (203) 724-0437

TITLE: **Project Orgullo Latino**

PROJECT DIRECTOR:
Dr. Merrill C. Singer

GRANT NO.:
D56MP93076-01

TARGET POPULATION:
Hispanics

LANGUAGE:
Spanish

The goals of the project are to lower AIDS risk and barriers to AIDS service delivery among gay and bisexual Latino men within the Hispanic Health Council's service area. The proposed project was developed in response to the comparatively high levels of infection in this population, and is culturally and socially geared to meet the special needs of the target population.

The project will have the following components: (1) community outreach to targeted Latino men for "street education" and recruitment as project participants; (2) formation of four HIV/STD/TB prevention education groups composed of individuals from the following subgroups: a) bisexual men, b) gay men, c) transvestites, and d) a mixed group for men who are uncertain of their sexual identities; (3) assessment of the social service and other needs of participants; (4) short-term case management; (5) advocated referrals for HIV/STD/TB health testing and services; (6) in-service training for health care providers in culturally competent service delivery; and (7) formation of ongoing prevention clubs among Latino co-sexual men.

Numerical targets are established for the number of men to be served. The Hispanic Health Council's goal is to increase AIDS knowledge levels and lower risk behavior by 25 percent among project participants.

DISTRICT OF COLUMBIA

Mary's Center for Maternal and Child Care, Inc.

1844 Columbia Road, N.W.
Washington, DC 20009
PHONE: (202) 483-8196
FAX: (202) 797-2628

TITLE: **PROYECTO BIENESTAR**

PROJECT DIRECTOR:
Ms. Maria S. Gomez

GRANT NO.:
D56MP93041-01

TARGET POPULATION:
Hispanics

LANGUAGE:
Spanish

Mary's Center for Maternal and Child Care, Inc., proposes an intervention project to increase access and reduce barriers to health care among limited-English-speaking Hispanic families in Washington, DC. The project would address needs resulting from the rapid influx of Hispanic immigrants into the District of Columbia over the last decade. The health care system and mainstream service providers could benefit from assistance in meeting the linguistic and cultural needs of this fast-growing, underinsured population. Goals of the project are to increase bilingual/bicultural direct health care and promotion services and to provide health care professionals with cultural and language training.

Specific project objectives are to affect the following increases: new family planning and pediatric participants (by 40 percent); at-risk children who receive a development evaluation (by 100 percent); parental knowledge and skills in infant language development and stimulation techniques in at least 70 of 80 trained parents (by 80 percent); and the knowledge and clinical judgement of delivering culturally sensitive services to the target community in 40 of 50 training workshop participants (by 50 percent).

The project would build on the services and infrastructure of an established health care center with strong linkages and proven programs with the target population.

HAWAII

Kalihi-Palama Health Center

766 N. King Street
Honolulu, HI 96817
PHONE: (808) 845-8578
FAX: (808) 841-1265

TITLE: **Kalihi-Palama Health Center Bilingual/Bicultural Outreach and Education Project**

PROJECT DIRECTOR:
Ms. Elizabeth Giesting

GRANT NO.:
D56MP93088-01

TARGET POPULATION:
Asians, American Samoans, Native Hawaiians, Pacific Islanders

LANGUAGE:
Ilocano, Tagalog, Visayan, Vietnamese, Samoan

The Kalihi-Palama Health Center has a 20-year history of working effectively with Southeast Asians and Pacific Islanders. It is located in the Honolulu neighborhood most densely settled by immigrants. The center serves a diverse group of Asian and Pacific Island immigrants and Native Hawaiians. A primary goal of the proposed project is to increase the number of health care providers who are attuned to the language and cultural barriers of these groups and to offer more appropriate care. A second goal is to work more closely with the Samoan, Vietnamese, and Filipino communities to outreach, educate, and empower their members.

The center proposes to develop training modules for current and prospective health care providers that would contain information about traditional therapies, health needs of various ethnic groups, the appropriate demeanor of the practitioner with regard to the ethnic culture of the patient, and working effectively with interpreters. The center would also recruit one Filipino and one Vietnamese health care trainee to work with a Samoan community health worker already on staff. They would be trained to educate their respective cultural communities about Western medicine and medical delivery systems, sources of affordable health care, and when primary and preventive care should be sought. In addition, the trainees would work with the center to improve culturally appropriate services.

The project's final goal is to increase the number of Filipino, Vietnamese, and Samoan patients using preventive and primary care services at the Kalihi-Palama Health Center. The center has set goals for increasing the number of target-group women receiving family planning services and perinatal services. The project aims to raise the percentage of target group children receiving timely immunizations from 30 percent to 60 percent.

MISSISSIPPI

Mississippi Band of Choctaw Indians - Choctaw Health Department

P.O. Box 6010 - Choctaw Branch
Philadelphia, MS 39350
PHONE: (601) 656-2211
FAX: (601) 656-1992

TITLE:
Choctaw Health Risk Reduction Education Project

PROJECT DIRECTOR:
Ms. Wanda Kittrell

GRANT NO.:
D56MP93035-01

TARGET POPULATION:
American Indians

LANGUAGE:
Choctaw

The Mississippi Band of Choctaw Indians (MBCI) proposes a culturally tailored project to establish a sustainable approach for delivering HIV/AIDS and related risk reduction education in eight reservation communities. As the sole provider of health care on the reservations, MBCI would employ a culturally acceptable format and a cadre of bilingual trainers well prepared to translate prevention information into Choctaw. The target population is the 6,000 members of the Choctaw tribe, which is experiencing a high rate of acute health problems and has no program for public awareness and prevention education.

In the target population, the dominant home and social language is Choctaw, an oral language virtually without a written component. The project would rely on the Choctaw Health Center's delivery system and its Choctaw-speaking community health technicians, maternal-child health home visitors, and bilingual community health licensed practical nurses. Staff would be trained in using the Red Cross AIDS curriculum to instruct in the Choctaw language.

The project would employ age- and gender-specific community training/focus groups and school classes for all students in grades 7 to 12 for risk reduction prevention education and as sources for obtaining evaluative data on the project's effectiveness. Evaluation findings would also inform development of a tribal plan for continuation and expansion of AIDS prevention activities for the general tribal population, as well as for specific groups practicing high-risk behaviors affecting their health.

NEW JERSEY

Puerto Rican Organization for Community Education and Economic Development, Inc.

815 Elizabeth Avenue
Elizabeth, NJ 07201
PHONE: (908) 351-7727
FAX: (908) 353-5185

TITLE: **Among Us/Entre Nosotras**

PROJECT DIRECTOR:
Ms. Zaida O. Castillo

GRANT NO.:
D56MP93084-01

TARGET POPULATION:
Hispanics

LANGUAGE:
Spanish

The principal goal of the project is to reduce the risk of HIV infection among Latino women. The proposed project would attempt to achieve this goal by increasing knowledge about HIV transmission among Latino women through a series of educational sessions. Topics included would be self-esteem, sexuality, drug use, nutrition, children and HIV, and empowerment through community involvement.

A second goal of the project is to promote group and peer support for the initiation and maintenance of behaviors that would reduce the risk of HIV infection among the target population. This would be accomplished by providing referrals for HIV related services to the target population and by promoting the development of an informal women's network.

The project would make extensive use of Safety Net Parties -informal social gatherings at which AIDS prevention, risk reduction and sexuality, and the correct use of condoms would be discussed.

Two support groups also would be organized to address the isolation and stigmatization experienced by drug abusers within the target population. In addition, individual health counseling sessions would be provided for women who need to discuss health related issues, but who are not ready to participate in a group.

OKLAHOMA

Cherokee Nation

P.O. Box 948
Tahlequah, OK 74465
PHONE: (918) 458-5785
FAX: (918) 458-5799 code 33

TITLE: **Teenage Pregnancy Prevention and Health Education**

PROJECT DIRECTOR:
Ms. Verna Thompson

GRANT NO.:
D56MP93065-01

TARGET POPULATION:
American Indians

LANGUAGE:
Cherokee

The Cherokee Nation proposes to develop a culturally relevant child sexual abuse curriculum for day care centers and provide culturally relevant training for parents and service staff. The project is designed to integrate new native-language-awareness classroom activities, which are mandated by the State, with the need to communicate more effectively with parents, child care providers, and children about child sexual abuse. The target population lives within the Cherokee Nation service area, comprises seven entire counties and portions of seven others, and includes a significant number of low-income, dysfunctional families and those for which English is a second language.

Project objectives are to develop and implement a child sexual abuse education program for more than 100 service staff, train 1,000 parents of Head Start and area public school students in areas of child development and sexual abuse prevention, and adapt a culturally relevant child sexual abuse prevention curriculum for preschool children.

TEXAS

Dallas Multicultural Alliance

4301 Bryan Street, Suite 206
Dallas, TX 75204
PHONE: (214) 828-9891
FAX: (214) 828-0567

TITLE: **Bilingual Dental Access Coalition**

PROJECT DIRECTOR:
Mr. Kham Ko Ly

GRANT NO.:
D56MP93037-01

TARGET POPULATION:
Asians, Hispanics

LANGUAGE:
Vietnamese, Laotian, Cambodian, Spanish

The Dallas Multicultural Alliance (DMA) proposes a project for community outreach and improved access to dental services. The target population is low-income, limited-English-speaking Cambodian, Lao, Vietnamese, and Hispanic children and their families in two Dallas, TX, inner-city neighborhoods -- East Dallas and Oak Lawn. These areas are characterized by a highly transient population, including numerous limited-English-speaking ethnic, refugee, and immigrant groups. The proposed project is a follow-up to findings from a citizen-led dental health task force in 1992, which showed that in 1991 only one-third of indigent children were served by a public dental care provider and only one in six Dallas County children who were enrolled in the Texas Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program actually went to the dentist.

Goals of the project are (1) to increase the target population~s knowledge of preventive dental care and the availability of services, and (2) to assist in accessing dental care funded under the EPSDT Program.

Project objectives include (1) training 40 bilingual volunteer interpreters to serve as ombudsmen in accessing dental care services, (2) conducting three bilingual community dental fairs to inform a minimum of 1,500 members of the target population about dental health and procedures for enrolling in the EPSDT Program, (3) ensuring provision of culturally competent dental care to 160 client households through dental screening examinations and followup by the ombudsmen, and (4) increasing cooperation among local health agencies, community-based organizations, and EPSDT dental providers so as to reduce linguistic barriers to dental care.

WASHINGTON

Asian Counseling and Referral Service

1032 S. Jackson Street, Suite 200
Seattle, WA 98104
PHONE: (206) 720-5300
FAX: (206) 461-8363

TITLE: **Southeast Asian Cross-Cultural Training Project**

PROJECT DIRECTOR:
Ms. Elisa Del Rosario

GRANT NO.:
D56MP93070-01

TARGET POPULATION:
Asians, Pacific Islanders

LANGUAGE:
Vietnamese, Cambodian, Laotian (Mien)

Asian Counseling and Referral Service (ACRS) proposes a two-fold effort to address barriers to health care access for limitedEnglish-speaking Asians and Pacific Islanders in its service delivery area. The project would include cross-cultural competency training and curriculum development related to mental health issues for Southeast Asians.

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Public Health Service ■ Office of Minority Health ■ 1-800-444-6472
OFFICE OF MINORITY HEALTH RESOURCE CENTER

Bilingual/Bicultural Service Demonstration Grants

Fiscal Year 1994

The Program

Program Description

Bilingual/Bicultural Service Demonstration Grants are administered and funded by the Office of Minority Health (OMH), U.S. Department of Health and Human Services (DHHS). The OMH was created in December 1985 to address the historical disparity between the health status of whites and that of racial and ethnic minorities.

In Fiscal Year 1994 DHHS awarded $2.6 million dollars for 35 new grants, located in fourteen States and the District of Columbia. The grants support projects that are run by community-based organizations linked with health care facilities.

Social, cultural, or linguistic differences between providers and clients can create barriers to good health care. These projects seek to improve the ability of health care providers and other health care professionals to deliver linguistically and culturally competent health services to populations that speak limited English.

In addition to developing cultural competency training programs for physicians, nurses and other professionals, these projects work to increase the use of case managers and outreach workers from the racial and ethnic communities that they serve. Bilingual/Bicultural Service Demonstration Grants help strengthen counseling, mentoring and support group programs, and enhance translation and interpreting services for minority populations.

Arizona

La Frontera Center, Inc.

W. 29th Street
Tucson, AZ 85713
(602) 884-9920.

Title:
Building Cultural Competence in the Workplace

Contact:
Dr. Floyd H. Martinez

Grant no:
D56MP95091-01-0

Target Population:
Hispanics (Mexican Americans)

Age Group:
Adolescents to Elderly

The goal of the project is to increase the cultural competence and linguistic capacity of the health care staff providing services to the local Hispanic population.

The project's objectives are:
1) 60 behavioral health care professionals who will complete 8 hours of cultural competency training; and,
2) 80 percent of the employees enrolled in Spanish classes will attend at least 80 percent of the sessions.

In addition, a program will be established to retain existing bilingual/bicultural staff and to attract new personnel.

California

Asian AIDS Project

785 Market Street, Suite 420
San Francisco, CA 94103
(415) 227-0946

Title:
Case Management/Education for High-Risk Asian/Pacific Islander Communities

Contact:
Vince Sales

Grant No:
D57MP940029-01-0

Target Group:
Asian/Pacific Islanders

Age Group:
Adolescents to Adults

The project's purpose is to develop and implement a case management and education program that targets limited-English-speaking Asians and Pacific Islanders: women that work in massage parlors, transgenders, and homosexuals.

The objectives will be to provide:
1) bilingual and bicultural case management services;
2) education and training on health and human services; and,
3) linkages between the health service providers and the target groups.

California

Asian Health Services

310 8th Street, Suite 200
Oakland, CA 94607
(510) 465-3271

Title:
Provider Education on Medical Interpretation

Contact:
Linda Okahara

Grant No:
D56MP94025-01-0

Target Population:
Asians

Age Group:
Adults to Elderly

The project will improve health care providers' communication with diverse non-English speaking patients in Alameda, CA.

Training will focus on how to use interpreters in order to communicate accurately and effectively with patients

California

Asian Americans for Community Involvement, Inc.

2400 Moorpark Avenue, Suite #300
San Jose, CA 95128
(408) 975-2730

Title:
Asian Seniors Health Promotion Project

Executive Director:
Jessie Doi-Cunha, Ed.D.

Grant No.:
D56MP95083-01-0

Target Population:
Asians and Pacific Islanders

Age Group:
Elderly

The project will reach Chinese, Vietnamese, Cambodian, and Laotian seniors in Santa Clara County.

The project will:
1) assess their health status;
2) provide lectures on Asian health care needs and specific health resources; and,
3) provide bilingual and bicultural translators and interpreters.

California

Association of Asian Pacific Community Health Organizations

1212 Broadway, Suite 730
Oakland, CA 94612
(510) 272-9536

Title:
Mapping the Way to Health

Contact:
Chantal Raymer

Grant No.:
D56MP94033-01-0

Target Population:
Asians (Koreans and Vietnamese)

Age Group:
All

The objective is to develop a pocket medical guide and a training manual for interpreters and clinical staff who provide interpretation services for Korean and Vietnamese patients in primary care settings.

The guide will contain ethnic-specific health information for medical interpretation, a glossary of human anatomy, and primary health care terms.

California

Cambodian Association of America

2501 Atlantic Avenue
Long Beach, CA 90806
(310) 988-1863

Title:
Bilingual/Bicultural Case Management Services Project

Contact:
Him Chhim

Grant No:
D56MP94045-01-0

Target Group:
Asians (Cambodians)

Age Group:
Children (newborn to age 5)

Case managers will:
1) provide culturally and linguistically appropriate medical case management for Cambodian families in Long Beach, CA;
2) conduct health care presentations for families and health care providers; and,
3) collect data on the health status of the Cambodian families living in the area.

California

Koryo Health Foundation

1058 S. Vermont Ave
Los Angeles, CA 90006
(213) 380-8833

Title:
Bilingual/Bicultural Training for Asian Pacific Islander Consumers and Health Care Providers

Grant No:
D56MP94049-01-0

Contact:
John Cho

Target Group:
Asians (Chinese, Koreans, Thais)

Age Group:
Adults to Elderly

The project will develop training curricula for Chinese, Korean, and Thai community health workers. A community resources directory of culturally and linguistically appropriate available health and social services in Los Angeles County will also be prepared.

California

Multicultural Area Health Education

5051 E. Third Street
Los Angeles, CA 90022
(213) 780-7640

Title:
East-West Health Care Communication Center

Contact:
Franco Reyna

Grant No:
D56MP94007-01-0

Target Group:
Hispanics

Age Group:
All

The project's intent is to reduce linguistic and cultural barriers which exist between Hispanic patients and health care providers. Language and cultural training sessions will be available for health care staff in the Los Angeles area.

California

The Cambodian Family

1111 E. Wakeham Ave., Suite E
Santa Ana, CA 92705
(714) 571-1966

Title:
Health Care Access for Cambodians

Contact:
Christina Woo-Sam

Grant No.:
D56MP94048-01-0

Target Population:
Asians (Cambodian)

Age Group:
Children to Adults

The purpose of the project is to raise health awareness, change behaviors and attitudes of Cambodians utilizing the health care services in Santa Ana, CA. Health education material will be developed and health translation services will be provided for the Cambodian community.

California

United Cambodian Community, Inc.

411 E. 10th St., Suite 207
Long Beach, CA 90813
(310) 491-9100

Title:
Breaking Down the Barriers - Strategies to Reach Southeast Asians

Contact:
Lillian S. Lew

Grant No:
D56MP94024-01-0

Target Group:
Asians (Cambodians, Laotians, Hmong, Vietnamese)

Age Group:
Prenatal to elderly

A health assessment of the Southeast Asian community in Long Beach, CA, will be conducted. Based on the appraisal, a training manual will be prepared on the culture and health needs/behaviors of the community.
Training will be provided for health and social service providers to increase their knowledge of the population thereby improving health care.

California

Vista Community Clinic

981 Vale Terrace
Vista, CA 92084
(619) 631-5010

Title:
Hospital Emergency Room Patient and Provider Education Project

Contact:
Rosa Navarro or Fernando Sanudo

Grant No.:
D56MP94004-01-0

Target Group:
Hispanics

Age Group:
All

The project will provide an education and referral service for Hispanic patients that use the San Diego, CA Tri-City Medical Center's emergency room for non-emergency visits. In addition, emergency room and clinic personnel will receive cultural competency training.

Colorado

Asian Pacific Development Center

1818 Gaylord Street
Denver, CO 80206
(303) 355 0710

Title:
CABA Project - Colorado Asian Bilingual Access Project

Contact:
Jae W. Ahn

Grant No:
D56MP94040-01-0

Target Population:
Asian Pacific Islanders

Age Group:
Adults to Elderly

The project is designed to improve the health of a growing limited-English-speaking Asian and Pacific Islander population in Colorado's Denver/Boulder metropolitan area.

The purpose of the project is to:
1) promote cultural competency in the health care professions;
2) remove language barriers;
3) improve the general well-being and health of Asian and Pacific Coloradans, and,
4) recruit Asian home health care workers to meet the needs of the elderly.

Connecticut

Bridgeport Community Health Center, Inc.

471 Barnum Avenue
Bridgeport, CT 06608
(203) 333-6864

Title: **Reduction of Language and Cultural Barriers to Care**

Contact: Wanda Jones

Grant No:
D56MP94053-01-0

Target Group: Southeast Asians (Laotian, Cambodian, Vietnamese)

Age Group:
Adults

The project will provide outreach, translation, and culturally sensitive health services to Southeast Asians and Hispanics in Bridgeport, CT.

Connecticut

Khmer Health Advocates, Inc.

545 Prospect Ave.
West Hartford, CT 06105
(203) 233-0313

Title:
Cambodian Health Assessment Project

Contact: Richard A. Miller or Mary Scully

Grant No:
D56MP94042-01-0

Target Group: Asians (Cambodians)

Age Group:
Adults to Elderly

The project will develop initial health interview protocols for use on Cambodian holocaust survivors for use by medical service providers. The interview instrument will take into account language, culture, history, trauma experience, and present symptoms.

District of Columbia

Central American Refugee Center

3112 Mount Pleasant St., N.W.
Washington, D.C. 20010
(202) 328-9799

Title:
Latino Health Care Project

Contact:
Amy Yergey

Grant No:
D56MP940010-01-0

Target Group:
Hispanics/Latinos (Central Americans)

Age Group:
All

The goals are to:
1) develop and pilot test a model for training health care providers (physicians and physician's assistants) in a community setting so as to increase their cultural sensitivity; and,
2) improve the health status of Latino children by providing health education to parents through outreach and parenting classes.

District of Columbia

Indochinese Community Center

1628 16th St. N.W.
Washington, D.C. 20009
(202) 462-4330

Title:
Southeast Asian Community Health Awareness

Contact:
Samarpita Das

Grant No:
D57MP940018-01-0

Target Group:
Asians (Indochinese)

Age Group:
Adolescents to Adults

The purpose is to improve access to health services by Southeast Asian women living in Northern Virginia. Workshops, field trips, and bilingual material will be used to educate women about natal care, family planning, and STD's/HIV. Cultural sensitivity training will also be provided for public and private health practitioners.

District of Columbia

Latin American Youth Center

3045 15th St., N.W.
Washington, D.C. 20009
(202) 483-1140

Title:
Proyecto Puente de Salud/Bridging Gaps in Health Care

Contact:
Carmen Duran-Medina

Grant:
D56MP94039-01-0

Target Group:
Hispanic

Age Group:
Youth to Adults

The project proposes to:
1) develop and implement a physician and a physician-in-training bicultural curriculum;
2) produce a bilingual multimedia health care services public awareness campaign; and,
3) evaluate the effectiveness of both initiatives.

District of Columbia

Mary's Center for Maternal and Child Care, Inc.

2333 Ontario Rd., N.W.
Washington, D.C. 20009
(202) 483-8196

Title:
Making Dreams Possible for Hispanic Teens

Contact:
Michelle Leeks

Grant No:
D56MP94038-01-0

Target Group:
Hispanics

Age Group:
Infants & Adolescents

The project plans to reduce linguistic and cultural barriers to health care faced by limited-English-speaking Hispanics and to increase access to medical, educational and social services for limited-English-speaking Hispanic teens and their infants.

Florida

Guatemalan Center, Inc.

110 North F. Street
Lake Worth, FL 33460
(407) 547-0085

Title:
HIV/AIDS Screening of Education for Mayans

Contact:
Jaime Zapata

Grant No:
D57MP940030-01-0

Target Group:
Guatemalans (Mayans)

Age Group:
Adolescents to Elderly

The focus of the project is to provide culturally sensitive and language-appropriate HIV awareness, assessment, education, testing, and referral services to Guatemalans-Mayans living in the Palm Beach County area.

Hawaii

Kalihi-Palama Health Center

766 North King Street
Honolulu, Hawaii 96817
(808) 848-1438

Title:
Bilingual/Bicultural Outreach and Education Project

Contact:
Susan Cole

Grant No:
D56MP94009-01-0

Target Group:
Asians and Pacific Islanders
(Filipinos, Koreans, Samoans,Vietnamese)

Age Group:
All

Health care access will be increased for limited-English-speaking Filipino, Korean, Samoan, and Vietnamese residents in the Kalihi-Palama locality of Hawaii.
Health education workers will be trained to facilitate perinatal support groups for the limited-English-speaking families in the region.

Illinois

Alivio Medical Center

2355 S. Western Avenue
Chicago, IL 60608
(312) 650-1202

Title:
Alivio Medical Center

Contact:
Carmen Velasquez

Grant No:
D56MP940035-01-0

Target Group:
Hispanic women & children

Age Group:
All

In order to increase the number of Spanish-speaking physicians, the project will help Hispanic medical students and physicians from Spanish-speaking countries, pass the required licensing exam in the United States.

In addition, the Medical Center will form a partnership with the West Side Future program. The collaborative effort will allow Hispanic patients of both organizations access to primary care services, Healthy Start Services, and Healthy Moms/Healthy Kids Service.

Illinois

Asian American AIDS Foundation

5412 N. Clark St., Suite 214
Chicago, IL 60640
(312) 989-7220

Title:
Multilingual and Multicultural Information on HIV/AIDS

Contact:
Edmann Mequi

Grant No:
D57MP940036-01-0

Target Group:
Asians/Pacific Islanders

Age Group:
Adolescents to Adults

The project will provide multicultural, multilingual information on AIDS/HIV and on the health services available to Asians living in the Chicago area. Over one dozen Asian languages are spoken in the area.

Illinois

Hispanic Health Alliance

760 N. Ogden Ave, Suite 2100
Chicago, IL 60622
(312) 455-2999

Title:
Provider Education Project

Contact:
Marily Santiago-Schettini

Grant No:
D56MP940046-01-0

Target Group:
Hispanics

Age Group:
Adults

The goal of the project is to improve health care professionals' effectiveness in the delivery of health care services to Hispanics. The project will provide language and cultural sensitivity training for health professionals.

Illinois

Vietnamese Association of Illinois

5252 N. Broadway, 2nd Floor
Chicago, IL 60640
(312) 728-3700

Title:
Chicago's Mutual Aid Association Health Education Project

Contact:
Ha Nguyen

Grant No:
D57MP940017-01-0

Target Group:
Cambodians, Chinese, Ethiopians, Laotian, Vietnamese

Age Group
Adolescents to Elderly

Four community organizations are collaborating to:
1) train Southeast Asian and African women to become information resource persons;
2) explain the health care system to refugees; and,
3) educate the population on the purpose of primary and preventative health care in Chicago's Uptown neighborhoods.

Massachusetts

Cambodian Community of Greater

Fall River
P.O. Box 5085, Flint Station
Fall River, MA 02723
(508) 676-8225

Title:
Cambodian Health Care Access Program

Contact:
Marion Vat

Grant No:
D56MP94051-01-0

Target Group:
Cambodians

Age Group:
All

The project addresses problems that limit access to health care by Southeast Asian refugees living in Fall River, MA. The project will implement the following activities:
1) develop and distribute a bilingual health care resource directory;
2) increase the number of certified health interpreters from 3 to 15;
3) place 15-25 qualified Khmer-speaking professionals in health-related jobs; and,
4) coordinate four cross-cultural sessions for health care providers on Cambodian medical practices, language, and health care beliefs.

Massachusetts

Gandara Mental Health Center

1985 Main Street
Springfield, MA 01104
(413) 736-8329

Title:
Bilingual/Bicultural Mental Health Training

Contact:
Henry East-Trou

Grant No:
D56MP94005-01-0

Target Group:
Vietnamese and Amerasian

Age Group:
Adults

The project will train mental health care providers who will provide services to Vietnamese living in the Springfield area. The project will recruit Vietnamese and Amerasians for training as mental health paraprofessionals.

Michigan

Lao Family Community, Inc.

735 E. Michigan Ave., 2nd floor
Lansing, MI 48912
(517) 485-0046

Title:
Health Care Project

Contact:
Cheu Xiong

Grant No:
D56MP94002-01-0

Target Group:
Asians (Lao/Hmong)

Age Group:
All

To better serve Laotian refugees, the project proposes to provide services (language and cultural sensitivity) for one or two hospitals in the areas of Ingham, Eaton, and Clinton, MI.

New Mexico

La Clinica del Pueblo de Rio Arriba

P.O. Box 104
Tierra Amarilla, NM 87575
(505) 588-9506

Title:
La Comunidad Sana

Contact:
Mark Nodine

Grant No:
D56MP940011-01-0

Target Group:
Hispanics

Age Group:
Adults to Elderly

The project will service northern New Mexico. Community health workers will be trained to provide the community with social casework, support counseling, and disease prevention education.

New Mexico

New Mexico Mutual Assistance

P.O. Box 8994
Albuquerque, NM 87198-8994
(505) 260-0126

Title:
Coalition for Health, Advocacy and Outreach (Project CHAO)

Contact:
Bobbie L. Nobels

Grant No:
D56MP94028-01-0

Target Group:
Asians (Vietnamese)

Age Group:
All

The project's aim is to improve access to health care for the Vietnamese population in Albuquerque. The project will develop a system in the community to train medical interpreters and health outreach workers and also to network with health care providers to decrease linguistic and cultural barriers.

New York

Chinatown Action for Progress, Inc.

125 Walker Street, 2nd Floor
New York, NY 10013
(212) 226-8866

Title:
Health Education for Chinese Immigrants

Contact:
Fanny Chin

Grant No:
D56MP940026-01-0

Target Group:
Asians (Chinese)

Age Group:
All

Bilingual and bicultural health education material on tobacco and oral health will be developed for Chinese immigrants. In addition, information on "managed health care" will be disseminated to the community.

New York

Metropolitan Athletics Congress,Inc.

57 Read St., 4th Floor
New York, NY 10007
(212) 227-0071

Title:
Health Care Access for Hispanic Youth

Contact:
Tracy Sundlun

Grant No:
D56MP94050-01-0

Target Group:
Hispanic (Puerto Ricans, Dominicans)

Age Group:
Youth

The goals of the project are to:
1) provide health services and follow up care; and,
2) instill a lifelong appreciation of the value of fitness as a contributor to good health and to self-esteem and self-confidence.
The target population are Puerto Rican and Dominican elementary school students in the South Bronx, NY.

Texas

Hispanic AIDS Committee

P.O Box 120190
San Antonio, TX 78212
(210) 732-2667

Title:
Alianza Contra El SIDA: HIV/STD/TB Education to Rural Hispanics

Contact:
Jesus M. Sanchez

Grant No:
D57MP940032-01-0

Target Group:
Hispanics

Age Group:
Adolescents to Adults

The program will provide bilingual HIV/STD/TB education to Hispanics in rural communities of San Antonio, TX. The project will also provide training to rural health providers who work with Spanish-speaking Hispanics in order that they continue to provide STD training after the termination of the grant.

Texas

Midwest Migrant Health

Information Office
P.O. Box 206
Mercedes, TX 78570

(210) 565-0002

Title:
Colonia Health Worker Program

Contact:
Elida Hernandez or Kimberly Krantz

Grant No:
D57MP94008-01-0

Target Group:
Hispanics

Age Group:
All

Ten Hispanic farmworkers will be trained as health workers to deliver health messages to their peers. The training will be on health education techniques, HIV/AIDS prevention, and referral activities.

Washington

Asian Counseling & Referral Service

1032 S. Jackson, Suite 200
Seattle, WA 98104
(206) 720-5302

Title:
Southeast Asian Cross-Cultural Training Project

Contact:
Elisa Del Rosario

Grant No:
D56MP94056-02-0

Target Group:
Asians
(Vietnamese, Cambodians, Laotians, Mein, Hmong)

Age Group:
Adults to Elderly

The focus is to train bilingual/bicultural interpreters to better interpret Euro-American mental health concepts for Southeast Asian clients. Interpreters will explain Southeast Asian cultural beliefs to the health care provider in King County, WA.

Wausau Area Hmong Mutual Association, Inc.

514 Fulton Street
Wausau, WI 54403
(715) 842-8390

Title:
Bilingual Health Improvement Project

Contact:
Yi Vang

Grant No:
D56MP94003-01-0

Target Group:
Asians

Age Group:
All

The project seeks to enhance the quality of bilingual health services for Hmong residents of central Wisconsin.
The project will:
1) develop a Hmong-English medical phrase book and medical interpreting guide;
2) train volunteers as medical interpreters; and,
3) develop and deliver educational sessions on preventive health.

A nationwide service of the U.S. Department of Health and Human Services
Public Health Service ■ Office of Minority Health ■ 1-800-444-6472

OFFICE OF MINORITY HEALTH RESOURCE CENTER

Bilingual/Bicultural Service Demonstration Grants

FISCAL YEAR 1995

The Program

Program Description

The Bilingual/Bicultural Service Demonstration Grant Program is administered and funded by the Office of Minority Health (OMH) of the U.S. Department of Health and Human Services (DHHS). The OMH was created in December 1985 to address the historical disparity between the health status of whites and that of racial and ethnic minorities. Its mission is to improve the health of racial and ethnic populations through the development of effective health policies and programs.

The Bilingual/Bicultural Service Demonstration Grant Program was developed in 1993 to reduce social, cultural and linguistic barriers between providers and clients with limited-English- proficiency, and to improve their access to good health care. The projects described in this fact sheet are funded for the three-year project period 9/30/95 through 9/29/98. The grants are administered by community-based organizations linked with health care facilities. These projects seek to improve the ability of health care providers and other health care professionals to deliver linguistically and culturally competent health services to populations that speak limited English.

Each of the projects offers activities unique to the needs of the target community. In addition to developing cultural competency training programs for physicians, nurses, and other professionals, the projects work to increase the use of case managers and outreach workers from the racial and ethnic communities they serve. They provide counseling, mentoring, and support group programs for clients who speak limited English, and enhance translation and interpreting services for minority populations. For additional information, please contact the Division of Program Operations, Office of Minority Health at (301) 594-0769.

AMERICAN SAMOA

American Samoa Government

Department of Health
LBJ Tropical Medical Center
Pago Pago, AS 96799
PHONE: 011 (684) 633-2243
FAX: 011 (684) 633-5379

Title:
Health Education Curriculum Improvement and Service Extension Project

Project Director:
Joseph Tufa, D.S.M., M.P.H.

Grant No.:
D56MP95091

Target Population:
Asian/Pacific Islander

Age Group:
All age groups

American Samoa, a United States territory located in the Pacific region, consists of five islands. It is a territory of minority populations, with the majority (approximately 97%) living on the main island of Tattily.

Health care services are provided by two main government agencies: LBJ Tropical Medical Center and the American Samoa Department of Health. The LBJ Tropical Medical Center is the island's only hospital and provides inpatient and outpatient care. The Department of Health is responsible for providing home care and preventive health care services, including health education programs.

The Department of Health is expanding its health education services to previously unserved or underserved communities. *The Health Education Curriculum Improvement and Service Extension Project* targets women from the islands' three main ethnic groups--Samoans, Tongans, and Filipinos--who have limited-English-speaking proficiency.

Health education materials are under development in the following subject areas: prenatal care, immunization, oral health care, and skin diseases/problems. Once designed, the materials will be translated into the appropriate languages. Some of these materials are videos in the Samoan language with Polynesian cast members. The videos will also be translated to the Tongan and Filipino languages. Culturally and linguistically appropriate training programs are also being prepared for health educators chosen by the Tongan and Filipino communities.

CALIFORNIA

Asian Aids Project

785 Market Street, Suite 420
San Francisco, CA 94103
PHONE (415) 227-0946
FAX: (415) 227-8945

Title:
HIV Case Management-Education to High Risk Asians and Pacific Islanders

Project Director:
John Manzon-Santos

Grant No.:
D56MP95078

Target Population:
Asian/Pacific Islander

Age Group:
Adults

Formed in 1987, the Asian Aids Project (AAP) was the first HIV/AIDS program in the United States to target the Asian Pacific Islander (API) community. In 1989, the AAP conducted a baseline survey of HIV/AIDS knowledge, attitudes, beliefs and behavior among Chinese and Japanese communities in San Francisco.

The HIV Case Management-Education to High Risk Asians and Pacific Islanders Project targets the following high risk groups for HIV infection: women working in massage parlors, transgender/transsexuals, and men who have sex with men. These groups currently have limited or inadequate access to HIV health services.

Over the three-year period of this project, AAP is: 1) increasing the utilization of health and human services through its case management-education model; 2) increasing the target group's future accessibility to health and human services through health education; and 3) expanding the cultural competency and linguistic capacity of health care professionals and para-professionals working with these groups. The project is providing in-service training and instituting referral protocols between and among health care organizations for the target groups.

CALIFORNIA

Asian Americans for Community Involvement, Inc.

2400 Moorpark Avenue, Suite #300
San Jose, CA 95128
PHONE: (408) 975-2730
FAX: (408) 975-2745

Title:
Asian Seniors Health Promotion Project

Project Director:
Carlina Yeung, M.S.W.

Grant No.:
D56MP95083

Target Population:
Asian/Pacific Islander

Age Group:
55 years and older

The Asian Seniors Health Promotion Project (ASHPP), conducted by Asian Americans for Community Involvement, Inc., serves as a point-of-entry program for seniors who have been unable to use or are distrustful of local health care services. The goal of the ASHPP is to bring seniors and the health care system in closer alignment. Problems that the project addresses include language and cultural barriers between the Asian seniors and the service providers, lack of knowledge about disease and disease management, and lack of trust and understanding of Western medical practices, including the complexity of the system itself.

The project offers six main activities: intercultural communication effectiveness workshops for health care providers, bicultural and bilingual volunteer training, health screenings, lectures, In-Home Promotion and Support Services, and an Information and Assistance Phone Support System.

The ASHPP recruits and trains bilingual and bicultural volunteers (Cambodian, Chinese, Laotian, and Vietnamese) to assist the Asian seniors. The project conducts health screenings to help the seniors learn about health problems and recognize their need for medical attention. Through the Information and Assistance Phone Support System, the project connects homebound seniors with health care services and case management services, including translation and transportation.

CALIFORNIA

Special Services for Groups

605 W. Olympic Blvd., Suite 600
Los Angeles, CA 90015
PHONE: (213) 553-1818
FAX: (213) 553-1812

Title:
Pacific Asian Language Services Project (PALS)

Project Director:
Heng L. Foong

Grant No.:
D56MP95068

Target Population:
Asian/Pacific Islander

Age Group:
All age groups

The Pacific Asian Language Services Project (PALS) is conducted by Special Services for Groups, a multi-service "umbrella" agency that provides an array of human services to ethnic minority communities and groups. This project is based on a PALS model previously developed in 1991 through the Special Services for Groups to address language issues that become problematic in the treatment of HIV/AIDS.

This PALS project has implemented a mobile, interpretation service staffed by bilingual/bicultural interpreters. The goal is to increase health care access for low-income, monolingual, limited- English-speaking residents of Los Angeles County, with special emphasis on areas with a high concentration of Asian Pacific Islanders (APIs).

PALS has assembled a team of trained interpreters, some of whom will be further trained in mental health assessments and crisis intervention. The language consultants who have mental health and crisis intervention skills help with the Psychiatric Emergency Teams at mainstream mental health clinics. Seminars are conducted to enhance the skills of the consultants in such areas as interpreter techniques, resources, medical updates, HIV/AIDS, tuberculosis, mental health, and women's health.

Promotion of the PALS project is two-tiered: outreach and education to the medical care providers is carried out through mass mailings, and consumers are targeted through the ethnic media. The project's promotion campaign uses bus stop advertisements, bill boards, and television public service announcements.

CALIFORNIA

The Cambodian Family

1111 E. Wakeham Ave., Suite E
Santa Ana, CA 92705
PHONE: (714) 571-1966
FAX: (714) 571-1974

Title:
Health Care Access for Cambodians

Project Director:
Rifka Hirsch

Grant No.:
D56MP95066

Target Population:
Asian/Pacific Islander

Age Group:
All age groups

The mission of The Cambodian Family is to help refugees develop knowledge, skills, and self-esteem to become self-reliant, contributing members of society. The Cambodian Family has been in existence since 1982 and its services include providing translation services for hospitals, doctors, and clinics, as well as offering health education programs for Cambodian families.

The Health Care Access for Cambodians Program seeks to build the skills of both providers and clients to bridge the gap between Western medicine practices and the traditional, spirit-oriented health practices of the new Cambodian arrivals. The primary target area is the neighborhood with the densest population of Cambodians in Orange County, an area referred to as the Minnie Street area. The program provides cultural and linguistic interpretation for health care providers, health screenings in the Cambodian community, health promotion among Cambodians, and cultural competence training systems. Seminars for health care providers include presentations on the Cambodian culture, health beliefs and health accessing behaviors, as well as working translators and non-literate clients. Project staff design, test and use culturally and linguistically appropriate health promotional materials.

Union of Pan Asian Communities

1031 25th Street
San Diego, CA 92102
PHONE: (619) 232-6454
FAX: (619) 235-9002

Title:
Southeast Asian Health Care Access Project

Project Director:
Irene Linayao-Putman

Grant No.:
D56MP95057

Target Population:
Asian/Pacific Islander

Age Group:
Adults

The Union of Pan Asian Communities (UPAC) has a 21-year history of providing services, both independently and in partnership with other health/human service providers, to San Diego's diverse Asian and Pacific Islander population. Among its many efforts, the organization addresses mental health, child abuse and domestic violence issues, as well as the cultural adjustment and language assistance needs of Southeast Asians.

The major goals of the *Southeast Asian Health Care Access Project* are to: 1) reduce barriers and improve access to cancer relevant health care among limited-English-proficient Vietnamese, Chinese-Vietnamese, Laotian, and Cambodians in San Diego County; and 2) improve the cultural competency level of local health care providers.

The project is involved in developing culturally and linguistically appropriate cancer screening and educational materials, and small group educational presentations; producing and disseminating a health services resource directory; conducting on-site visits to cancer-relevant health care facilities; and providing interpretation services and cultural competency training for health care providers.

The project has health education materials in several Chinese languages, including Cantonese, Mandarin, Chau Chieu, Toisan and Taiwanese. Materials are being adapted and translated into four Southeast Asian languages (Vietnamese, Chinese, Lao and Cambodian). UPAC is also preparing a bilingual health care resource directory in Chinese/English, Vietnamese/English, Cambodian/English and Laotian languages.

Training programs on cancer are conducted for patients, as well as providers. Topics include health information on hepatitis B and cancers of the liver, lung, cervix, and breast. Prevention strategies take into account knowledge, attitudes, beliefs, and values of targeted ethnic groups toward cancer in general, and more specifically toward preventive health care practices, early cancer detection procedures, and various cancer treatment options. Project staff participate in an ongoing review program of cancer terminology to ensure accurate translations.

Vista Community Clinic

956 Vale Terrace, Suite 201
Vista, CA 92084
PHONE: (619) 631-5040
FAX: (619) 631-5010

Title:
Medical Interpretation and Cultural Competency Training Project for Community Clinic Support Personnel

Project Director:
Fernando Sanudo

Grant No.:
D56MP95012

Target Population:
Hispanic

Age Group:
All age groups

Vista Community Clinic has offered health care and health education since 1972 for those residents who have been unable to access care due to economic, social, or cultural barriers. Its Health Promotion Center is known for its innovative and culturally sensitive health promotion and disease prevention programs.

The Medical Interpretation and Cultural Competency Training Project for Community Clinic Support Personnel (MICC) is developing a medical interpretation and cultural competence training program for community clinic support personnel in San Diego County. Topics address such issues as professional and ethical conduct, intercultural issues, technical vocabulary in both languages, pre-interpreting skills and consecutive interpreting. The support personnel are also trained to elicit accurate information from the limited-English-speaking patients.

A medical interpretation and cultural competence training manual for use in the *Train a Trainer* program has been pilot tested in several community clinics in San Diego, Orange County and Imperial Valley. Upon completion of the course, trainers are certified in the MICC program. The program has linked with local colleges where medical assistant programs are conducted in an effort to institutionalize the *Train the Trainer* program for medical interpretation and translation. In the last year of this project, the MICC program will be modified for use with district hospital support personnel. This will enhance the interpretation and cultural competency skills of support personnel who can also provide interpretation for medical personnel in hospitals, emergency room, and urgent care facilities.

DISTRICT OF COLUMBIA

La Clinica del Pueblo

1470 Irving Street, N.W.
Washington, D.C. 20010
PHONE: (202) 462-4788
FAX: (202) 667-3706

Title:
Bilingual/Bicultural Interpreter Services Project

Project Director:
Juan Romagoza, M.D.

Grant Number:
D56MP95100

Target Population:
Hispanic/Latino

Age Group:
All Ages

La Clinica del Pueblo, founded in 1983, is the only free bilingual/bicultural medical clinic for Hispanics and Latinos in the Washington, D.C. area. It serves more than 7,000 clients per year. The clinic offers a predominantly Central American population access to primary health care and subspecialty medicine. Health areas include adult primary care, diabetes, mental health, AIDS, neurology, rheumatology, occupational medicine, reproductive health, adolescent medicine, pediatrics, and dermatology.

The goals of the *Bilingual/Bicultural Interpreter Services Project* are to: 1) establish on- and off-site culturally appropriate interpreter services; 2) provide on-site education to health care providers; 3) conduct cultural sensitivity workshops; and 4) develop a culturally appropriate English-Spanish dictionary comprised of 300 words that are unique to predominantly Central American countries, including slang phrases and key medical words. Through the activities of this project, La Clinica del Pueblo is addressing the barriers to health care encountered by its target population, such as the inability to pay for health insurance, linguistic isolation, lack of cultural sensitivity in the medical profession, and fear of government institutions.

DISTRICT OF COLUMBIA

Mary's Center for Maternal and Child Care, Inc.

2333 Ontario Road, NW
Washington, D.C. 20009
PHONE: (202) 483-8196
FAX: (202) 797-2628

Title:
Proyecto Conexion

Project Director:
Maria S. Gomez, R.N.

Grant Number:
D56MP95002

Target Population:
Hispanic/Latino

Age Group:
Prenatal through Adult

Mary's Center for Maternal and Child Care, Inc. (Mary's Center), established in 1988, is a non-profit, minority community-based agency. It focuses on increasing access to health care for limited-English-proficient (LEP) Hispanic and Latina women and children through the provision of low-cost, comprehensive services.

The goal of *Proyecto Conexion* is to decrease barriers and increase access to culturally and linguistically appropriate health care for the target population. Project activities are divided into three primary components.

Entitlement Assistance provides guidance in applying for services including Medicaid, food stamps, emergency assistance, and Social Security.

The Home Visiting Team, in partnership with Providence Hospital, provides education, counseling, HIV/AIDS testing/counseling, advocacy, immunizations, and case management services for pregnant women and babies from the prenatal stage to one year of age.

Pediatric Case Management provides assistance and education to ensure proper child development.

ILLINOIS

City of Chicago

Office of Hispanic Affairs
Chicago Department of Health
DePaul Center, Second Floor, Room 2144
333 S. State Street
Chicago, Illinois 60604
PHONE: (312) 747-8820
FAX: (312) 747-9694

Title:
Chicago Department of Health Bilingual/ Bicultural Service Demonstration Project

Project Director:
Esther Sciammarella

Grant Number:
D56MP95036

Target Population:
Hispanic and Latino

Age Group:
Adults

The Chicago Department of Health (CDOH), Office of Hispanic Affairs, addresses the physical and mental health of Hispanic and Latino residents through the CDOH Health Clinics. The clinics provide effective and accessible health services that emphasize health promotion and disease prevention.

The goal of the *CDOH Bilingual/Bicultural Service Demonstration Project* is to improve the effectiveness of health care delivery to limited-English-proficient Hispanics. This project focuses on five of the seven CDOH clinics used by the target population. Intensive language and cultural sensitivity training is provided to health care professionals, including doctors and nurses, and paraprofessionals from the Sexually Transmitted Disease, Tuberculosis, and Immunization units. This training increases their knowledge of the values, beliefs and culture of the Hispanic community, and improves the level of communication between provider and patient.

KANSAS

Wichita-Sedgwick County

Department of Community Health
1900 East Ninth
Wichita, Kansas 67214
PHONE: (316) 268-8342
FAX: (316) 268-8397

Title:
Bilingual/Bicultural Service Demonstration Project

Project Director:
Margaret Baker

Grant Number:
D56MP95087

Target Populations:
Hispanic and Asian

Age Group:
All Ages

The Wichita-Sedgwick County Department of Community Health (WSCDCH) is responsible for protecting the citizens of Wichita-Sedgwick County from excessive morbidity by preventing the spread of disease, encouraging a healthy life style, and providing a safe environment. The WSCDCH's Personal Health Division provides clients with both primary and preventive health services.

The Bilingual/Bicultural Service Demonstration Project focuses on a comprehensive approach to improving the ability of health care providers and other professionals to deliver linguistically and culturally competent health service to limited-English-speaking Hispanics and Asians. Two WSCDCH Health Stations have been established within the Asian and Hispanic communities to improve the delivery of all health services, with an emphasis on cancer prevention for Hispanics, and health assessments and referrals for Asians.

The activities of this project also emphasize: early enrollment of patients in the Maternal and Infant Program; routine clinical breast examinations, mammograms and Pap tests; and compliance with direct-observed therapy by Asian clients. Other activities include the translation of health education materials, the purchase of health education materials that are language and reading level appropriate, and promotion of bilingual/bicultural services.

MICHIGAN

Midwest Migrant Health Information Office, Inc.

502 W. Elm Avenue
Monroe, Michigan 48162
PHONE: (313) 243-0711
FAX: (313) 243-0435

Title:
Colonia Health Worker Program

Project Director:
June Grube-Robinson, M.P.H.

Grant Number:
D57MP95041

Target Population:
Hispanic and Latino

Age Group:
All Ages

The Midwest Migrant Health Information Office, Inc. (MMHIO), is a nationwide lay health promotion agency that strives to provide full access to health services and improve health conditions for migrant farm workers and their families. Although headquartered in Michigan, MMHIO maintains a facility in the Rio Grande Valley, Texas, that works closely with health care providers, community service agencies and farm workers.

The *Colonia Health Worker Program* targets poor Hispanic residents of the colonias of the Rio Grande Valley. It has trained twelve migrant farmworkers to be effective peer health educators and serve as a crucial link between colonia residents and the health care system. The training emphasizes culturally sensitive information on HIV/AIDS. The trained peer health educators participate in home visits and distribute HIV/AIDS health information to the residents of the colonias, and provide health-related referrals to Valley agencies. The peer health educators also provide information on the conditions and lifestyles of colonia residents to health professionals enabling them to provide more culturally and linguistically appropriate health care.

NEW YORK

African Services Committee, Inc.

28 East 35th Street
New York, New York 10016
PHONE: (212) 683-5021
FAX: (212) 779-2862

Title:
Bilingual/Bicultural Access to HIV/STD/TB Medical Services for African Refugees and Immigrants

Project Director:
Kim Nichols

Grant Number:
D57MP95076

Target Population:
African Immigrants and Refugees

Age Group:
Prenatal, Infants, and Adults

The African Services Committee, Inc., a 13-year old community-based organization, provides services to African immigrants and refugees who require access to medical services within the five boroughs of New York City. These services include multilingual outreach, HIV pre- and post-test counseling, and HIV resource referral. In 1993 and 1994, the organization expanded its services to provide testing, treatment and follow up for Sexually Transmitted Diseases (STD) and Tuberculosis (TB).

The *Bilingual/Bicultural Access to HIV/STD/TB Medical Services for African Refugees and Immigrants* project provides culturally competent interpretations and translations, HIV/STD/TB prevention education, medical counseling, and referral and follow-up services to prevent and reduce the risk of infection for this population. Project services include:
1) an escort to pre-test screenings, as well as interpretation and counseling for clients;
2) referrals to primary medical care and follow up for positive diagnoses, including prophylaxis for opportunistic infections, direct observed therapy and STD treatment;
3) short-notice and emergency interpretations and translations at hospitals; and
4) bilingual attitude, belief and behavioral risk assessments.

St. Joseph's Hospital

158-40 79th Avenue
Flushing, New York 11366
PHONE: (718) 558-6211
FAX: (718) 558-6209

Title:
Culturally Sensitive Primary Care Services to the Korean Community of Queens, New York

Project Director:
Andrea Dell Ensley-Williams, M.H.A.

Grant Number:
D56MP95038

Target Population:
Korean

Age Group:
All Ages

St. Joseph's Hospital, a 200-bed community hospital, is located in the Queens Borough of New York City, an area with a diverse mix of ethnic and racial groups. According to the 1990 Census, 64 percent of the 70,598 Koreans living in New York City are concentrated in St. Joseph's primary and secondary service areas.

The project's overall goal is to improve access to primary care services by the limited-English-proficient Korean community. Hindered by language barriers, this population experiences some difficulty in understanding the health care system.

To achieve the goals and objectives of this project, St. Joseph's Hospital has established linkages with a community-based organization, Korean Community Services (KCS) and the American Cancer Society.

Through these partnerships, the project offers community-based health education and screening programs, low-cost/no cost mammography and cervical screenings, age-appropriate health maintenance services and counseling, interpreter support, translation of patient information and education materials, outreach services, and cultural awareness and basic language training for the hospital staff.